V. S. No. 2
100M—5-43
Rev. 5-17-39
I X36671

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 3 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12253

Registration District No. 149 | Primary Registration District No. 1002 | Registrar's No. 1811

48
3
8

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Lukes Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution one week (Specify whether years, months or days)
In this community 1 week

2. USUAL RESIDENCE OF DECEASED: 949
(a) State Kansas (b) County 14
(c) City or town Wellsville Kans (If outside city or town limits, write "RURAL")
(d) Street No. Route #1 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Ada E. Hayes
3. (b) If veteran, name war No
3. (c) Social Security No. No
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife John R. Hayes
6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased March 25 1880 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
65 ~~64~~	~~12~~ 0	27	hr. min.

9. Birthplace Kansas (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name Newton P Chandler
13. Birthplace Pa (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Eliza Harrison
15. Birthplace Mo Record (City, town, or county) (State or foreign country)
16. (a) Informant John R Hayes
(b) Address Wellsville Kans - Route #1
17. (a) Removal (Burial, cremation, or removal) **(b) Date thereof** April 23-45 (Month) (Day) (Year)
(c) Place: burial or cremation Baldwin Kans
18. (a) Signature of funeral director Mrs C C Foster
(b) Address 914 Brooklyn
19. (a) 4-23-45 (Date received local registrar) **(b)** Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22 year 1945 hour 11 minute 40 P. M.
21. I hereby certify that I attended the deceased from July 5, 1948 to Apr 22, 1945 that I last saw her alive on Apr. 22, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinomatosis abdomen with intestinal obstruction	4 wks
Due to: Carcinoma of Sigmoid colon	2 1/12 yrs.
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operation: Carcinoma of Sigmoid colon
Of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature L. P. Engel (M. D. or other) M.D.
Address Plaza Med Bldg K.C. Mo Date signed 4-23-45

(Licensed Embalmer's Statement on Reverse Side)

Dr. Engel

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate, was embalmed by me or by .....

....., Registered Apprentice No. .....,

working under my personal supervision.

Signed .....

Licensed Embalmer No. .....

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.