

S. No. 2
OM-5-43
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26456**

FILED AUG 27 1945

Registration District No. _____

Primary Registration District No. **1002**

Registrar's No. **3299**

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

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:
2610 ASKEW. 1
(If not in hospital or institution, write street number of location)
(d) Length of stay: In hospital or institution **4 YEARS.** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **JACKSON**
(c) City or town **KANSAS CITY** ?
(If outside city or town limits, write "RURAL")
(d) Street No. **2610 ASKEW AVENUE** 8
(If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **MR CHRISTOPHER COMMODORE HINES**

3. (b) If veteran, name war **NO** 3. (c) Social Security No. **513-01-6551-A**

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **WIDOWED**

6. (b) Name of husband or wife **DRUSEILLA HINES** 6. (c) Age of husband or wife if alive **—** years

7. Birth date of deceased **MARCH 23 1868**
(Month) (Day) (Year)

8. AGE: Years **77** Months **3** Days **12** If less than one day _____ hr. _____ min.

9. Birthplace **BAYFIELD MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation **CARPENTER**

11. Industry or business _____

MOTHER FATHER { 12. Name **WILLIAM C. HINES**

13. Birthplace **UNKNOWN**
(City, town, or county) (State or foreign country)

14. Maiden name **ELIZABETH KELLOGG**

15. Birthplace **UNKNOWN**
(City, town, or county) (State or foreign country)

16. (a) Informant **Rolla E. Hines**

(b) Address **2610 Askew Avenue**

17. (a) **Burial** (b) Date thereof **Aug 8 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Atchison, Kansas**

18. (a) Signature of funeral director **S. J. Newcomers, D.D.S.**

(b) Address **1401 Brush Creek Blvd**

19. (a) **8-6-45** (b) **Geraldine Holmes**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **5** year **1945** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **August 2**, 19**45** to **August 5**, 19**45** that I last saw him alive on **August 5**, 19**45** and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage** Duration **1 day**

Due to **arterio sclerosis**

Due to _____

Other conditions: **830**
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations: _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury **0**

23. Signature **Robert Jansen** (M. D. or other) **M.D.**

Address **2220 E. 31st St** Date signed **8-6-45**

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 Emile M. Calhoun

Licensed Embalmer No. # 3506

P. O. Address K. C. Mo.

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.