

STANDARD CERTIFICATE OF DEATH

Registration District No. 149

Primary Registration District No. 1002

State File No.

Registrar's No. 5233

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: TRINITY LUTHERAN HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 30 DAYS (Specify whether
In this community 25 YEARS 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. TANNER HOTEL 917 LOCUST
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country NONE

3. (a) PRINT FULL NAME MRS ROSENA HAYES

(b) If veteran, name war no
(c) Social Security No. NONE

4. Sex FEMALE
5. Color or race W
6. (a) Single, widowed, married, divorced WIDOW
(b) Name of husband or wife LUCIEN L HAYES
(c) Age of husband or wife if alive 14 years 1876
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 69 Months 11 Days 3
If less than one day hr. min.

9. Birthplace ST LOUIS MISSOURIA
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business

MOTHER FATHER
12. Name HOWELL MOSS SEARCY
13. Birthplace KENTUCKY
(City, town, or county) (State or foreign country)
14. Maiden name WINIFERD SMITH
15. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)

16. (a) Informant MRS NANCY NAOMI GILBERT
(b) Address TANNER HOTEL 917 LOCUST

17. (a) CREMATION (b) Date thereof 12-20-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation D. W. Newcome's SONS QUIRK & TOBIN

18. (a) Signature of funeral director 20 W LINWOOD
(b) Address

19. (a) 12-20-45 (b) St. Aldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month pathologist Dec.
year 17, 1945 hour minute M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia
Gangrenous Colitis.
Due to Chronic Nephritis
(arteriosclerotic)
Due to Hypertensive Cardiovascular Disease
Other conditions (Cardiac Hypertrophy)
(Include pregnancy within 3 months of death)

Major findings: Of operations 120a
Of autopsy above.

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 _____
Signature Jacob Hill (M. D. or other) M.D.
Address Trinity Lutheran Hosp. Date signed 16 Dec 45

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

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

Charles M. Burk

Licensed Embalmer No.

3774

P. O. Address

R. E. M.

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.