

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13471
Registrar's No. 1962

FILED MAY 12 1947

Registration District No. 149

Primary Registration District No. 1002

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:
SINCLAIR FILLING STATION S.W. CORNER 39TH BROADWAY
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3
(Specify whether years, months or days)

In this community 52 YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON

(c) City or town RURAL
(If outside city or town limits, write "RURAL")

(d) Street No. 7201 SYCAMORE R.R. #2, KANSAS CITY
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME MR. CLEM JOHN HAIN

3. (b) If veteran, name war No

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 30TH
year 1947 hour 10 minute 45 A.M.

21. I hereby certify that I attended the deceased from 1941 to 4-30-47
that I last saw him alive on Apr 26 1947
and that death occurred on the date and hour stated above.

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife MRS. VIRGINIA HAIN

6. (c) Age of husband or wife if alive 42 years

7. Birth date of deceased JANUARY 16 1890
(Month) (Day) (Year)

Immediate cause of death Coronary Thrombosis

Due to Atherosclerosis

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

8. AGE:	Years	Months	Days	If less than one day
	<u>57</u>	<u>3</u>	<u>14</u>	hr. min.

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

10. Usual occupation OWNER AND OPERATOR

11. Industry or business SINCLAIR FILLING STATION

Major findings: Of operations 940

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

12. Name ANTHONY HAIN

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

14. Maiden name EMMA BOEGER

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

16. (a) Informant Mrs. Virginia Hain

(b) Address 7201 Sycamore

17. (a) BURIAL (Burial, cremation, or removal)

(b) Date thereof MAY 5-1947
(Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEMETERY

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? _____

18. (a) Signature of funeral director D. H. Newcomer, Son

(b) Address 1401 BRUSH CREEK BLVD

19. (a) 5-2-47 (Date received local registrar)

Heraldine Holmes (Registrar's signature)

While at work? yes (Specify type of place)

(e) Means of injury NO

23. Signature Dorothy Hogan (M. D. or other) MD

Address 801 1/2 W. 39th St Date signed Apr 30 47

801 1/2 West 39th Street
2

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 Melvin Miller
Licensed Embalmer No. 4907
P. O. Address Kansas City 3, 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.