

S. No. 2  
M-5-43  
7-5-17-39  
I X34871

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:  
Clara Steva Nursing Home, 1310 E. Armour  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 6 days 4  
(Specify whether years, months or days)  
 In this community 3 1/2 years

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Jackson **48**  
 (c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 2730 Harrison  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** WILLIAM J. HAYES  
 3. (b) If veteran, name war No 3. (c) Social Security No. None  
 4. Sex Ma 5. Color or race Wh 6. (a) Single, widowed, married, divorced Widowed  
 6. (b) Name of husband or wife Mary Hayes 6. (c) Age of husband or wife if alive XX years  
 7. Birth date of deceased March 4 1865  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month Dec. day 21  
 year 1948 hour 11: minute 50 A. M.  
 21. I hereby certify that I attended the deceased from Jan 24, 1949  
 to Dec 21, 1948  
 that I last saw him alive on Dec 21, 1948  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death Pneumo-pneumonia 2 days

**8. AGE:** Years Months Days If less than one day  
83 9 17 \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to arterio-sclerosis  
Senility  
 Due to \_\_\_\_\_  
 Other conditions Chor Myocarditis  
(Include pregnancy within 3 months of death)

**9. Birthplace** Springfield Illinois  
(City, town, or county) (State or foreign country)

**10. Usual occupation** Retired Farmer

**11. Industry or business** No Record  
**MOTHER** {  
**FATHER** {  
 12. Name \_\_\_\_\_  
 13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)  
 14. Maiden name \_\_\_\_\_  
 15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

**PHYSICIAN**  
 Major findings:  
 Of operations \_\_\_\_\_  
93  
 Of autopsy \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

**16. (a) Informant** John A. Hayes  
**(b) Address** 2730 Harrison  
**17. (a)** Burial **(b) Date thereof** 12-23-48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
**(c) Place:** burial or cremation Pilot Grove, Mo.

**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?  
Joseph G. Fogarty  
 While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury  
**23. Signature** Joseph G. Fogarty (M. D. or other) DD  
**Address** 1402 Northrup, St. Louis Date signed 1/21/49

**18. (a) Signature of funeral director** J. W. Wagner  
**(b) Address** Kansas City, Mo.  
**19. (a)** 12-21-48 **(b)** Heraldine Holmes  
(Date received local registrar) (Registrar's signature)

JAN 10 1949

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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 Alvin R Harnschild

Licensed Embalmer No. 4159

P. O. Address Kansas City 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.**