

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41635

State File No. 5418

FILED JAN 5 1952

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
c. LENGTH OF STAY (in this place) 3 1/2 mo.		d. STREET ADDRESS (If rural, give location) 4512 Benton Blvd.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4512 Benton Blvd.			

3. NAME OF DECEASED (Type or Print)	a. (First) Mary	b. (Middle) Theresa	c. (Last) Hayes	4. DATE OF DEATH (Month) (Day) (Year) 12 15 51
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 11-18-69	9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) St. Joseph, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Edig Wagner	13b. MOTHER'S MAIDEN NAME Theres Vonarx	14. NAME OF HUSBAND OR WIFE Stephen D. Hayes
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs. William Caulfield	ADDRESS K.C., Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 12/12/51 4201
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Lobour Pneumonia		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Coronary disease	
		DUE TO (c) Cardiac failure	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **12/12, 1951** to **12-16-1951**, that I last saw the deceased alive on **12-15-1951**, and that death occurred at **4:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE Anthony Saladino (Degree or title) Anthony Saladino M.D.	23b. ADDRESS 1040 Argyle Pkwy	23c. DATE SIGNED 12-16-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 12-16-51	24c. NAME OF CEMETERY OR CREMATORY ---	24d. LOCATION (City, town, or county) (State) St. Joseph Mo.
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DATE REC'D BY LOCAL REG. 12-17-51	REGISTRAR'S SIGNATURE Sheraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE Melody-McGilley-Eylar	ADDRESS 1800 E. Linwood
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WRITE PLAINLY—USING UNEADING BLACK INK—MAKE A PERMANENT RECORD

USA 7464

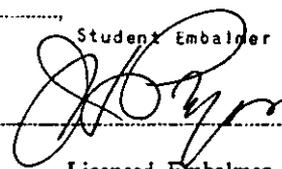
STATEMENT BY LICENSED EMBALMER

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

working under my personal supervision.

Student Embalmer No.

Signed _____



Licensed Embalmer No. 2997

Signed.....
Student Embalmer

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.