

FILED JUL 12 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18960
Registrar's No. 2516

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

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) OR TOWN KANSAS CITY c. LENGTH OF STAY (in this place) Life

c. CITY OR TOWN KANSAS CITY
Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL
e. STREET ADDRESS (If rural, give location) 4133 Euclid Ave., 3628

3. NAME OF DECEASED a. (First) LEE b. (Middle) CHARLES c. (Last) HAYS
4. DATE OF DEATH (Month) (Day) (Year) June 1, 1954

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH April 19, 1892 9. AGE (In years last birthday) 62

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur-Truck Driver 10b. KIND OF BUSINESS OR INDUSTRY Trucking Lines 11. BIRTHPLACE (City and State or Foreign Country) Kansas City, Kansas 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Robert Hays 13b. MOTHER'S MAIDEN NAME May Sarsfield 14. NAME OF HUSBAND OR WIFE Margaret M. HAYS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WORLD WAR I 16. SOCIAL SECURITY NO. 514-05-9563 17. INFORMANT'S SIGNATURE OR NAME Mrs. MARGARET M. HAYS ADDRESS 4133 Euclid Ave. Kansas City Mo.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma Squamous Cell Larynx
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Bronchopneumonia, terminal
INTERVAL BETWEEN ONSET AND DEATH 3 years
1101X
4 days

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

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)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from March 26, 1954, to June 1, 1954, and that death occurred at 9:35 P.m., from the causes and on the date stated above.

23a. SIGNATURE HARRY A. KNAUFF, M.D. (Please print name and title) 23b. ADDRESS VA Hospital Kansas City Missouri 23c. DATE SIGNED 6/2/54

24a. BURIAL, CREMATION REMOVAL (Specify) BURIAL 24b. DATE JUNE 4 1954 24c. NAME OF CEMETERY OR CREMATORY Mt. St. Mary's Cemetery 24d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI

DATE REC'D BY LOCAL REG. 6-4-54 REGISTRAR'S SIGNATURE Geraldine Smith 25. FUNERAL DIRECTOR'S SIGNATURE D. H. Neumann's Sons ADDRESS 1331 BRUSA CREEK KANSAS CITY, MO.

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

HARRY A. KNAUFF

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 Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Rose M. Soy*
Licensed Embalmer No. *450*
P. O. Address *K 610*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.