

Health,  
Welfare  
Public  
Service

FILED SEP 19 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31903  
STATE FILE NUMBER 3970  
Registrar's No.

Registration District No. 149 Primary Registration District No. 1002

300  
-57

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> *b. COUNTY <b>JACKSON</b> ✓		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS City,</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>KANSAS City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Trinity Lutheran Hosp.</b>		Length of stay in 1b <b>13 YEARS</b>	e. STREET ADDRESS <b>5006 WABASH</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Edward P HAYES</b>			4. DATE OF DEATH Month Day Year <b>August-22-1957</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 17, 1902</b>	9. AGE (In years last birthday) <b>55</b> IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Findley Lake, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13a. FATHER'S NAME <b>GEORGE HAYES</b>		13b. MOTHER'S MAIDEN NAME <b>ALICE WOODWARD</b>		14. NAME OF HUSBAND OR WIFE <b>MRS. GLADYS M. HAYES</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>495-05-1820</b>	17. INFORMANT Address <b>MRS. GLADYS M. HAYES 5006 WABASH AVE. KANSAS CITY MO.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>				INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Myocardial Insufficiency</b>		7 or 8 years	
		DUE TO (c)		4201	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>1950</b> to <b>Aug. 22, 57</b> and last saw her alive on <b>Aug 21, 57</b> Death occurred at <b>5:45 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Do give or title) <b>J.W. Grauerholz M.D.</b>			22b. ADDRESS <b>35-27 Broadway K.C. Mo.</b>		22c. DATE SIGNED <b>8/22-57</b>
23a. BURIAL (CREMATION, REMOVAL Specify) <b>BURIAL</b>	23b. DATE <b>AUG. 24 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. MORIAN CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>KANSAS City MISSOURI</b>	
24. FUNERAL DIRECTOR <b>D.W. NEWCOMER SONS</b>		ADDRESS <b>1831 Brush Creek Blvd</b>	25. DATE RECD. BY LOCAL REG. <b>8-24-57</b>	26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>	

J.W. Grauerholz USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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

Student .....  
Signature of Student Embalmer

Signed *Basel J. [Signature]*

Licensed Embalmer No. *2172*  
P. O. Address *[Signature]*

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.