

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000292
STATE FILE NUMBER

FILED JAN 12 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 5

300
-57

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Andrew	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Amazonia Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital		Length of stay in lb 12 years	d. STREET ADDRESS (If outside, give location) Box 245 Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First EDNA Middle MAUDE Last HAYNES			4. DATE OF DEATH Month January , Day 3 , Year 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March, 12, 1901	9. AGE (In years last birthday) 57 yrs.	IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Plattsburg, Missouri	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Robert Parker	13b. MOTHER'S MAIDEN NAME Rose Hamm	14. NAME OF HUSBAND OR WIFE Bert L. Haynes, (deceased)
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Year, no, or unknown) (If yes, give war or dates of service) No.	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. William West, Amazonia, Mo.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral & retinal arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 mo
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) left lung and Diabetes both left and right DUE TO (c) Spinal Cord Tumor. Death		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition involved in PART I (b) 518x		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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
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21. I attended the deceased from 1957 to 1959 and last saw her alive on 1-3-59 Death occurred at 4:30 A. m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Donald C. Forrester M.D.	22b. ADDRESS Lamar 7th	22c. DATE SIGNED 1-4-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jan. 5, 1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri
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24. FUNERAL DIRECTOR Stoney Funeral Home	ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. Jan. 5, 1959	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell
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All diseases in Part I must be causally related. Dr. Forrest C. Long USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE MEDICAL CERTIFICATION

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 *Charles E. Bennett*

Licensed Embalmer No. *4677*

P. O. Address *St. Joseph 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.