

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009440

STATE FILE NUMBER
1464

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1464

FILED APR 8 1959

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, give TOWNSHIP only) OR TOWN **Kansas City** Inside Limits Yes No

c. CITY OR TOWN **Kansas City** 7000 Inside Limits Yes No

c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION **Northeast Hospital** Length of stay in 1b **2 days**

d. STREET ADDRESS (If outside, give location) **8815 Lexington** Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last
HOMER M HAYNES

4. DATE OF DEATH Month Day Year
March 18 1959

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH **January 26 1903** 9. AGE (In years last birthday) **56** IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Retired**

10b. KIND OF BUSINESS OR INDUSTRY **Sheffield Steel**

11. BIRTHPLACE (City and state or country) **Macon Missouri**

12. CITIZEN OF WHAT COUNTRY? **USA**

13a. FATHER'S NAME **Leon Haynes** 13b. MOTHER'S MAIDEN NAME **Estella Frazier** 14. NAME OF HUSBAND OR WIFE **LaVina Haynes**

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. **486-12-3888** 17. INFORMANT Address **Mrs LaVina Haynes 8815 Lexington K C Mo**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Subdural Hemorrhage**
DUE TO (b) **Subdural Rupture**
DUE TO (c) **Arteriosclerosis**
CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.

INTERVAL BETWEEN ONSET AND DEATH **Few hours**
2 hours
5 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) **Cerebral Hemorrhage July 1956** 19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.

20d. INJURY OCCURRED WHILE AT NOT WHILE AT WORK

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 **July 1956** to **Mar. 18, 1959** and last saw him alive on **Mar. 18, 1959**
Death occurred at **5:00 P.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **J. G. Jamison M.D.** 22b. ADDRESS **5400 Dunlap Ave. K. C. Mo. 3-20-59** 22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 23b. DATE **3/21/59** 23c. NAME OF CEMETERY OR CREMATORY **Maple Hill Cemetery** 23d. LOCATION (City, town, or county) (State) **Kansas City Kansas**

24. FUNERAL DIRECTOR ADDRESS **Sheil Funeral Home Kansas City Mo** 25. DATE RECD. BY LOCAL REG. **3-20-59** 26. REGISTRAR'S SIGNATURE **Irene Marshall**

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
H. G. Jamison

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 *Thomas A. Shaw*

Licensed Embalmer No. *4954*
P. O. Address *S. C. M.*

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.