

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-017735

STATE FILE NUMBER 2316

FILED JUN 9 1959

Registration District No. 149 Primary Registration District No. 1002

Registrar's No.

300  
-57

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 <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Gen. Hospital		Length of stay in lb 2 1/2 year.	d. STREET ADDRESS (If outside, give location) 3312 1/2 Troost
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Myron VICTOR Haines			4. DATE OF DEATH Month Day Year 5 8 59		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-21-1900	9. AGE (In years) 58	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (City and state or country) Vinton, Iowa	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME John Haines	13b. MOTHER'S MAIDEN NAME Arizona Langham	13c. NAME OF HUSBAND OR WIFE Mildred Haines
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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. 483-24-6601	17. INFORMANT Mrs. Mildred Haines; 3312 1/2 Troost, 2 cm.	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) Acute coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) myocardial infarction DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). 4201		

20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 4201
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. 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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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
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21. I attended the deceased from 5-6-59 to 5-8-59 and last saw him alive on 5-8-59 Death occurred at 10:40 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) Abraham Galperin D	22b. ADDRESS General Hospital	22c. DATE SIGNED 5-9-59
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 5-10-1959	23c. NAME OF CEMETERY OR CREMATORIUM Center Point Cemetery	23d. LOCATION (City, town, or county) (State) Center Point, Iowa
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24. FUNERAL DIRECTOR Neilert, Funeral Homes; (5) 2/2 C. Mo	25. DATE RECD. BY REG. 5-9-59	26. REGISTRAR'S SIGNATURE Neva Marshall
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(Licensed Emballer's Statement on Reverse Side)

All diseases in Part I must be causally related.  
MEDICAL CERTIFICATION  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Abraham Galperin M.D.

**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 ..... *B E Weichert* .....

Licensed Embalmer No. *7075* .....

P. O. Address *Chesapeake, Md.* .....

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.