

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028481

FILED VS AUG 19 1959

STATE FILE NUMBER

Registration District No. 73 Primary Registration District No. 4133 Registrar's No. 97

1. PLACE OF DEATH a. COUNTY Clay				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Clay					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kearney		Length of stay in lb Lifetime		c. CITY OR TOWN Kearney		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION none			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) None		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Strother Middle Yates Last Haynes				4. DATE OF DEATH Month Aug. Day 5, Year 1959					
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 12-7-1889	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer			10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (City and state or country) Clay Co., Mo.		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME James M. Haynes			13b. MOTHER'S MAIDEN NAME Rose Thompson			14. NAME OF HUSBAND OR WIFE Allelee 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. Yes, Unk		17. INFORMANT B. E. Haynes, Kearney, Mo.		Address			
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 hemorrhage							INTERVAL BETWEEN ONSET AND DEATH 3 wks		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)									
DUE TO (c) Generalized peripheral arteriosclerosis							4 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input 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.)					
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year								
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 13 July 59 to 5 Aug 59 and last saw him alive on 4 Aug 59 Death occurred at 6:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>[Signature]</i> (Degree or title)				22b. ADDRESS Liberty, Mo				22c. DATE SIGNED 7 Aug 59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8-7-59	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		23d. LOCATION (City, town, or county) Kearney, Mo.				
24. FUNERAL DIRECTOR Fry Funeral Home, Kearney, Mo.				25. DATE RECD. BY LOCAL REG. 8-12-59		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 16 1959



STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

~~or by~~ _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Lindell Jarman

Licensed Embalmer No. 4589

P. O. Address Excelsior Springs

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.