

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-015376

FILED VS MAY 16 1960

149

Registration District No. \_\_\_\_\_ Primary Registration District No. 1002 Registrar's No. 2374 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Johnson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kansas City,</b>		Length of stay in 1b <b>4 days</b>	c. CITY OR TOWN <b>Spring Hill</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>V.A. Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Route 2</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Hayward</b> Last <b>Hayward</b>			4. DATE OF DEATH Month <b>4th</b> Day <b>26th</b> Year <b>1960</b>			
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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>3-24-92</b>	9. AGE (last birthday) <b>68 yrs</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Welder</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	11. BIRTHPLACE (City and state of country) <b>Urica, Michigan</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>
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13a. FATHER'S NAME <b>Frank Hayward</b>	13b. MOTHER'S MAIDEN NAME <b>Stella Freeman</b>	14. NAME OF HUSBAND OR WIFE <b>Valentine Hayward</b>
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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) <b>Yes 9/19/17 to 6/10/19</b>	16. SOCIAL SECURITY NO. <b>510078184</b>	17. INFORMANT <b>Valentine Hayward, Springhill, Ks</b> <b>VA Hospital Records, K.C., Mo.</b>	Address <b>Wife</b>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerotic heart disease</b>	
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic glomerulonephritis, cerebral arteriosclerosis previous CVA</b>		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	
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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. _____ 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.) <b>VA</b>	20f. CITY, TOWN, OR LOCATION <b>VA</b>	COUNTY _____ STATE _____
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21. Attended the deceased from **April 22, 1960** to **April 26, 1960**  
Death occurred at **2:05 am** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>ROBERT W. BROWN</b>	(Degree or title) <b>MD</b>	22b. ADDRESS <b>V.A. Hospital, K.C., Mo</b>	22c. DATE SIGNED <b>4/26/60</b>
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23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>April 29 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Olathe Kansas</b>
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24. FUNERAL DIRECTOR <b>D/W. Newcomers Sons 1331 Brush Creek Blvd,</b>	ADDRESS <b>Kansas City Missouri</b>	25. DATE RECD. BY LOCAL REG. <b>4-28-60</b>	26. REGISTRAR'S SIGNATURE <b>Reva Minchall</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

**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 *W. J. Nelson*

Licensed Embalmer No. 4421

P. O. Address Kennett 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.