

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-036948

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5159

FILED OCT 27 1961

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		Length of stay in 7b D.O.A.	c. CITY OR TOWN Raytown Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) \ HOSPITAL OR INSTITUTION Lakeside Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 11007 E. 78th Street Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First RAYMOND Middle H Last HAYNES			4. DATE OF DEATH Month October Day 15 Year 1961		
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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 7/6/1896	9. AGE (last birthday) 65	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) Meat Cutter	10b. KIND OF BUSINESS OR INDUSTRY Market	11. BIRTHPLACE (City and state or country) Cambridge, Ohio	12. CITIZEN OF WHAT COUNTRY U. S. A.
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13a. FATHER'S NAME William Haynes	13b. MOTHER'S MAIDEN NAME Evie Williams	14. NAME OF HUSBAND OR WIFE Madeline Holt Haynes
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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) Yes World War I	16. SOCIAL SECURITY NO.	17. INFORMANT Address Madeline Haynes, 11007 E. 78th St.
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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) Acute coronary occlusion	DUE TO (b) atherosclerosis	2 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c)	yes.

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
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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.)
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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 checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION Raytown	COUNTY Jackson	STATE Missouri
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21. I attended the deceased from 7/15/61 to 10/15/61 and last saw him alive on 10/15/61 Death occurred at 11:55 A.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) M.R. Lippman, D.O.	22b. ADDRESS 9140 E. 50 Hwy	22c. DATE SIGNED 10/16/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct. 17, 1961	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City Missouri
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24. FUNERAL DIRECTOR ADDRESS D.W. Newcomer; Sons, Kansas City, Mo	25. DATE RECD. BY LOCAL REG. 10-16-61	26. REGISTRAR'S SIGNATURE Ruth H. Long
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

M.R. Lippman

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

JUL 6 1962

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

Herold B. Carter

Licensed Embalmer No. 3035

P. O. Address C. Carter

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.