

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-038726  
5300 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 749 Primary Registration District No. 1002 Registrar's No. 5300

**FILED NOV 1 1962**

VS 300  
Rev. 4/59

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2 372  
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4 0  
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>17 YEARS</u>	c. CITY OR TOWN <u>KANSAS CITY</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Luke's Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1421 West 50th Terrace</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Lyle</u> Middle <u>GRAHAM</u> Last <u>Hait</u>			4. DATE OF DEATH Month <u>10</u> Day <u>18</u> Year <u>1962</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6/19/1912</u>
9. AGE (last birthday) <u>50</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WHOLESALE FURNITURE SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ARTISTIC FURNITURE CO.</u>	11. BIRTHPLACE (City and state or country) <u>LEAVENWORTH, KANS., U. S. A.</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13. FATHER'S NAME <u>JACOB HAIT</u>	
14. MOTHER'S MAIDEN NAME <u>IDA WOLFSON</u>		14. NAME OF HUSBAND OR WIFE <u>MRS. MAXINE HAIT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WORLD WAR II</u>		17. INFORMANT <u>MRS. MAXINE HAIT</u> Address <u>1421 WEST 50TH TERR. KANSAS CITY, MO.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO (b) <u>arteriosclerotic Heart Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs. ?</u>
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 checked="" 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 <u>Oct 10/62</u> to <u>Oct 17/62</u> and last saw him alive on <u>Oct 17/62</u> Death occurred at <u>2:10 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>A. J. Spafford M.D.</u>		22b. ADDRESS <u>315 Widdlers Rd Kansas City, Mo.</u>	22c. DATE SIGNED <u>10/18/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>OCT. 18, 1962</u>	23c. NAME OF CEMETERY OR CREMATOR <u>MT. ZION CEMETERY</u>	23d. LOCATION (City, town, or county) STATE <u>LEAVENWORTH KANSAS</u>
24. FUNERAL DIRECTOR <u>D. W. NEWCOMER'S SONS</u>	ADDRESS <u>1331 BRUSH CR. KANSAS CITY, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>10-18-62</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>

Dr. Allen Ely Hoffmann  
226 Perry Medical Bldg - 315 Medical Road  
D.C. 45 - nham

**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 Robert Ray

Licensed Embalmer No. 4182

P. O. Address K. C., 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.