

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-019428

STATE FILE NUMBER

Registration District No. 393 Primary Registration District No. 1002 Registrar's No. 2766

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 6008

2 6068

3

4 0

5 1

6

7 0

8 2

9 4200

10

11

12 90.0

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

FILED MAY 29 1963		1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Clay</u>		a. STATE <u>Missouri</u> COUNTY <u>Clay</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>Life</u>		c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4030 North Oak St.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>4301 North Virginia</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William J. P. Hayde</u>			4. DATE OF DEATH <u>May 11, 1963</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>3-28-1902</u>		9. AGE (last birthday) <u>61</u>		IF UNDER 1 YEAR IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Dept. Agriculture</u>		11. BIRTHPLACE (City and state or country) <u>(North) Kansas City, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>William Patrick Hayde</u>		13b. MOTHER'S MAIDEN NAME <u>Ida Welsh</u>	
14. NAME OF HUSBAND OR WIFE <u>Lillian Hayde</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>[redacted]</u>	
17. INFORMANT <u>Wife</u>		18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH	
		IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>		<u>3 weeks</u>	
		DUE TO (b) <u>Arteriosclerotic heart disease</u>		<u>approx. 5 years</u>	
		DUE TO (c)			
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 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 <u>[redacted]</u> a.m. <u>[redacted]</u> p.m. <u>[redacted]</u> Month, Day, Year <u>[redacted]</u>		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>7-12-62</u> to <u>5-11-63</u> and last saw ^{her} him alive on <u>5-11-63</u> . Death occurred at <u>3:30</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Donald A. Fakhoury, M.D.</u>			22b. ADDRESS <u>4030 N. Oak St., Kansas City 16, Mo</u>		22c. DATE SIGNED <u>5-13-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>5-14-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri North</u>
24. FUNERAL DIRECTOR ADDRESS <u>Melody-McGilley-Eylar 20 W. Linwood K.C. Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>5-13-63</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

USE BLACK INK OR TYPEWRITER RIBBON

Isl 3-0900
Dr. Fakhoury
until 5:30 pm
4030 N. Oak

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 Hayd A. Dickmon

Licensed Embalmer No. 5120

P. O. Address K.C. 11, 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.