

JAN 8 1941
Registration District No. 899

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
General Hospital #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution II-4-40-12-31
(Specify whether
In this community 17 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Kansas
(If outside city or town limits, write "RURAL")
(d) Street No. 917 Euclid
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Robert Haynes (Banks)

8. (b) If veteran, name war 760 8. (c) Social Security No. 760

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased II-13-1921
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>19</u>	<u>I</u>	<u>18</u>	hr. _____ min.

9. Birthplace Texas
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____

12. Name James Haynes

13. Birthplace Texas
(City, town, or county) (State or foreign country)

14. Maiden name Arville Washington
15. Birthplace Texas
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Record Clerk
(b) Address General Hospital #2

17. (a) Burial (b) Date thereof 1-3-41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Lincoln R.C.M.

18. (a) Signature of funeral director Adkins Bros.
(b) Address 2000 E. 12th St. K.C.Mo.

19. (a) 12-31-40 (b) M. M. Grow
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12-31- day 1940
year _____ hour: I minute 55 P. M.

21. I hereby certify that I attended the deceased from II-4-40
_____, 19____, to 12-31-40, 19____;
that I last saw him alive on 11-4-40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Abscess of lung
Type unknown

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
Means of injury _____
23. Signature A. C. Turner (M. D. or other) _____
Address _____ Date signed _____

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Cause of death to be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *Edw. Stevens.*

Licensed Embalmer No. *3836*

P. O. Address *1819 E. 15th St. 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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 41648
Registrar's No. 5041

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
General Hospital #2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11-4-40-12-31-40
(Specify whether
In this community 17 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 917 Euclid Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Robert Haynes (Banks)

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 11 13 1921
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>19</u>	<u>1</u>	<u>18</u>	<u>1</u> hr. _____ min.

9. Birthplace Texas
(City, town, or county) (State or foreign country)

10. Usual occupation Unemployed

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Arnetta Washington
15. Birthplace Texas
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk

(b) Address Gen. Hosp. #2

17. (a) Burial (b) Date thereof 1-3-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Buried in Brooks

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Dec 31 1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 31
year 40 hour 1 minute 55 P. M.

21. I hereby certify that I attended the deceased from 11-4- 1940, to 12-31- 1940,
that I last saw h. im alive on 12-31- 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis

Due to Secondary Abscess of Liver

Due to _____
Other conditions 230
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature R. P. [Signature] (M. D. or other) _____
Address Gen. Hosp. #2 Date signed ?

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

S-411648 - 1940

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.