

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-024369

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3395

STATE FILE NUMBER

**FILED JUL 5 1963**

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

GEO. C. Keathley et

ITEM NO. SHOULD READ

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) <u>KANSAS CITY</u>		Length of stay in 1b <u>12 YEARS</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) <u>3923 THE PASSEO</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside/give location) <u>3923 THE PASSEO</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>JOSEPH ALFRED HAYES, JR.</u>			4. DATE OF DEATH Month <u>JUNE</u> Day <u>14</u> Year <u>1963</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8-19-1934</u>	9. AGE (last birthday) <u>28</u>	IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HAIR DRESSER</u>		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (City and state or country) <u>CLEVELAND, OHIO</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>JOSEPH ALFRED HAYES, SR.</u>		13b. MOTHER'S MAIDEN NAME <u>BEULAH MARSH</u>	
14. NAME OF HUSBAND OR WIFE -		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. -	
17. INFORMANT <u>MRS. BEULAH HAYES, N.C. Mo.</u>		18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO (b) <u>cause undetermined</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 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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.					
22. SIGNATURE <u>Geo. C. Keathley and Ruth H. Lang</u>			22b. ADDRESS <u>6627 Prospect St. Omaha</u>		22c. DATE SIGNED <u>6-15-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>JUNE 18 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GRAND ISLAND CITY</u>		23d. LOCATION (City, town, or county) (State) <u>GRAND ISLAND NEBRASKA</u>
24. FUNERAL DIRECTOR <u>D.W. NEWCOMERS SONS, N.C., Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>6-17-63</u>		26. REGISTRAR'S SIGNATURE <u>Ruth H. Lang</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

**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 *Lamin Dunt*

Licensed Embalmer No. 4096

P. O. Address F.C. 7th

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.