

1939 JUN 12 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

17015
Do not use this space.

1. PLACE OF DEATH

(a) County 2 Registration District No. 791
(b) Township Primary Registration District No. 1008
(c) City St. Louis (d) Street No. 1119a Clara St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

340 William Hyatt
(a) Residence, No. 1119a Clara St. 5
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Kate Hyatt

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) (unk)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
ab. 58 - -

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Tailor
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 1936
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kaunas Lithuania

FATHER
13. NAME Joel Hyatt

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lithuania

MOTHER
15. MAIDEN NAME Ethel Grill

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lithuania

17. INFORMANT Maurice Hyatt
(ADDRESS) 1119a Clara

18. BURIAL, CREMATION, OR REMOVAL
PLACE Beth Ham Hag DATE 5/18 1939

19. FUNERAL DIRECTOR (NAME) H. B. Berger
(ADDRESS) 4715 McPherson

20. FILED MAY 18 1939 J. D. Brubaker Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-17-1939

22. I HEREBY CERTIFY, That I attended deceased from Dec. 1938 to May-17-1939

I last saw him alive on 5-17-1939 Death is said to have occurred on the date stated above, at 4 P. m.

The principal cause of death and related causes of importance were as follows:

Coronary Occlusion Date of onset Dec-38

Other contributory causes of importance:

Ch. Bronchitis Date of onset 1934-35

Name of operation Date of

What test confirmed diagnosis? E.K.G. Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Chas. S. Roman, M. D.

(Address) 408 W. Main St. Bldg. 57. Kansas Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

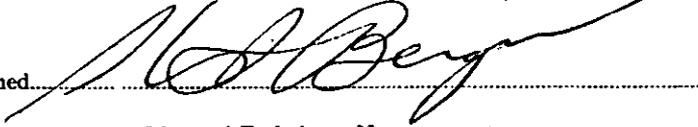
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FORM 4-19-34 I X16035

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.....

HERBERT J. BERGER, 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 with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.