DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 12907

MAY 15 1949 7911

Registration District No. _____ Primary Registration District No. 1003 Registrar's No. 3109

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.

1. PLACE OF DEATH:

(a) County _____

(b) City or town St.Louis (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: En route City Hospital No.1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St.Louis (If outside city or town limits, write "RURAL") 19

(d) Street No. 512 N.Whittier St (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME George Hathaway

3. (b) If veteran, name war *****

3. (c) Social Security No. 577-12-9825

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Divorded

6. (b) Name of husband or wife Unknown

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

7. Birth date of deceased October 5 1890 (Month) (Day) (Year)

8. AGE: Years 49 Months 5 Days 23 If less than one day _____ hr. _____ min.

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

10. Usual occupation Salesman

11. Industry or business Unemployed

MOTHER FATHER

12. Name William H.Hathaway

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

14. Maiden name Gertrude Lawson

15. Birthplace Missouri (City, town, or county) _____ (State or foreign country)

16. (a) Informant's own signature W S Hathaway

(b) Address Wellington Kansas

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof April 4 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Missouri Crematory

18. (a) Signature of funeral director Peetz Brothers

(b) Address 3029 Lafayette Ave

19. (a) APR 4 1940 (Date received local registrar) (b) _____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 28th year 1940 hour 4 minute 22 P M.

21. I hereby certify that I attended the deceased from _____, 19__, to _____, 19__; that I last saw h_____ alive on _____, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death External Hemorrhage from nose and lip. Subarachnoid hemorrhage of brain: TIME, PLACE CAUSE AND MANNER OF SAME COULD NOT BE DETERMINED. OPEN VERDICT

Duration

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) OPEN

(b) Date of occurrence Unknown

(c) Where did injury occur? Unknown (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Unknown (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

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.

Not Embalmed

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

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