

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **30710**
Registrar's No. **7987**

Registration District No. **791** Primary Registration District No. **1003**

FILED OCT 25 1940

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer G. Phillips Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Hr., 50 Min.
(Specify whether years, months or days) 2 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town St. Louis 18
(If outside city or town limits, write "RURAL")
(d) Street No. 4016 Papin
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Angela Marie Hynes

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

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

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

7. Birth date of deceased 8-16-40
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 2 If less than one day hr. _____ min.

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Claude Willie Hynes
13. Birthplace 4016 Papin
(City, town, or county) (State or foreign country)
14. Maiden name Estelle Johnson
15. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Arthur Mays Sherard
(b) Address 2601 N Whittier

17. (a) Burial (b) Date thereof 9-26-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director Ma. Hamilton
(b) Address City Health Dept.

19. (a) SEP 25 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 18
year 1940 hour 6 minute 1 M.

21. I hereby certify that I attended the deceased from 8-16- 1940 to 8-18- 1940
that I last saw her alive on 8-18-40
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Duration

PHYSICIAN

Major findings: Of operations _____
Of autopsy As above

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 [Signature] (M. D. or other) i
Address 2601 N Whittier Date signed 9-25-40

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

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 with the above constitutes grounds for revocation of license.)

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