

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **33930**
Registar's No. **8627**

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

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 **Missouri Baptist**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 days**
(Specify whether
In this community **2 days**
years, months or days)

3. (a) PRINT FULL NAME **Baby Hayes**

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

4. Sex **Male** 5. Color or race **White** 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 **Oct. 17 1940**
(Month) (Day) (Year)

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

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

10. Usual occupation **Nil**

11. Industry or business **0**

12. Name **James Hayes**

13. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Roxie Parker**

15. Birthplace **Fredericktown Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **James Hayes**

(b) Address **2838a Missouri**

17. (a) **Burial** (b) Date thereof **10/19/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Matthew's Cem.**

18. (a) Signature of funeral director **Wacker - Helder**

(b) Address **2131 So. Broadway**

19. (a) **OCT 19 1940** (b) **J. F. Under**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **24**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **2838a Missouri Ave.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. **-----** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **19**
year **1940** hour **4:30** minute **8** A. M.

21. I hereby certify that I attended the deceased from **Oct 17-1940**
to **Oct 19-1940**
that I last saw him alive on **Oct 19-1940**
and that death occurred on the date and hour stated above.

Immediate cause of death **Intestinal Shuntulation**

Due to **Congenital eversion**

Due to **Born with intestines outside of Abdominal Cavity**

Other conditions **15th**
(Include pregnancy within 3 months of death)

Major findings: Of operations **none**

Of autopsy **none**

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

(a) Accident, suicide, or homicide (specify) **none**

(b) Date of occurrence **none**

(c) Where did injury occur? **none**

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

While at work **none** (Specify type of place)

23. Signature **Wacker - Helder** (M. D. or other)

Address **2838a Missouri Ave.** Date signed **10/19/40**

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.