No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 18 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29773

Registration District No. 791 — Primary Registration District No. 1003 — Registrar's No. 7111

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

1. PLACE OF DEATH:

(a) County St. Louis-Mo

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

(c) Name of hospital or institution: 4046 Cook 1
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 000

(c) City or town ~~4046 Finney~~ St. Louis Ave 117 9
(If outside city or town limits, write "RURAL")

(d) Street No. 4046 ~~Finney~~ Cook Ave.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Corinne Hayes

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female 3

5. Color or race Col

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

6. (b) Name of husband or wife Willie Edgar Haynes

6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased February 25, 1889
(Month) (Day) (Year)

8. AGE: Years 52 | Months 6 | Days 6 | If less than one day ..... hr. ..... min.

9. Birthplace Montgomery City, Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Charles Sharon
13. Birthplace Danville, Mo. 0
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Glover, Annie
15. Birthplace Danville, Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Willie Edgar Haynes
(b) Address 4046 Cook Avenue

17. (a) Slater, Mo. (Burial, cremation, or removal) (b) Date thereof Sept. 4, 1941
(Month) (Day) (Year)
(c) Place: burial or cremation Slater, Mo.

18. (a) Signature of funeral director Allen Darles
(b) Address 3506 Franklin

19. (a) Sep 2 1941 (Date received local registrar) (b) J. P. Bredick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 31
year 1941 hour 9 minute A M.

21. I hereby certify that I attended the deceased from Aug 27, 1941 to Aug 31, 1941
that I last saw her alive on Aug 20, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Cardia Asthma

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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)
(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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature A. M. Craddock (M. D. or other)
Address 1003 Chiffingwell Date signed Sept 2

(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 William C. McDowell, Registered Apprentice No. ..... working under my personal supervision.

Signed William C. McDowell

Licensed Embalmer, No. 2114

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, fact should be so stated above.

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STANDARD CERTIFICATE OF DEATH

State File No. 29773

Registration District No. 791 Primary Registration District No. 1003 Registrar's No.

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:
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Corinne Hayes

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F.

5. Color or race Col

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

6. (b) Name of husband or wife

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 52 Months 6 Days 6 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ Slater, Mo.

18. (a) Signature of funeral director
(b) Address

19. (a) NOV 24 1941 (Date received local registrar) (b) J F Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 31
year 1941 hour minute 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

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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)
(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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

29773