

No. 2
1-4-41
5-17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33273
8228
Registrar's No.

Registration District No. 791 Primary Registration District No. 1003

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: DePaul Hospital D
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community Birth (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Catherine Hayes
3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Roy Hayes 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: August 13, 1903
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
38 1 26 hr. min.

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

10. Usual occupation House wife

11. Industry or business _____

MOTHER FATHER
12. Name James Cannon
13. Birthplace Not known Ireland
(City, town, or county) (State or foreign country)
14. Maiden name Catherine Ferrey
15. Birthplace Not known England
(City, town, or county) (State or foreign country)

16. (a) Informant Roy Hayes
(b) Address R. 4 Box 959 Halls Ferry Rd.

17. (a) Burial (b) Date thereof 10/17/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Friedens Cemetery

18. (a) Signature of funeral director Math Hermann & Son
(b) Address 2161 East Fair Ave

19. (a) Oct 16 1941 (b) J. F. Brudeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 000
(a) State Missouri (b) County St. Louis
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. Route 4 Box 959 Halls Ferry Rd. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)

~~name of doctor~~
MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 14th
year 1941 hour 10:45 minute A. M.

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

Immediate cause of death Atelectasis of both lungs following ether anesthesia while undergoing an operation
Due to at De Paul Hospital about 10:45 A.M. October 14th 1941
for Tumor of the Uterus,
type unknown

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: Hysterectomy
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) Accident

(b) Date of occurrence Oct 14 1941

(c) Where did injury occur? St. Louis Mo
(City or town) (County) (State)

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

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

23. Signature Thomas Halloran (M. D. or other)
Address Equity Center Date signed 10/16/41

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 Howard Hampton
Licensed Embalmer No. 2917
P. O. Address St. Louis, Mo

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.