

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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

8745

State File No. \_\_\_\_\_

3051

FILED APR 17 1942  
Registration District No. \_\_\_\_\_

Primary Registration District No. 1003

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Luke's Hospital  
(If not in hospital or institution, write street number or location) 0  
(d) Length of stay: In hospital or institution 10 Days  
(Specify whether years, months or days)  
In this community 10 Days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Illinois (b) County Randolph  
(c) City or town Sparta  
(If outside city or town limits, write "RURAL") NR  
(d) Street No. 112 West Mound St.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME Mary McGuire Hyndman  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month April day 4  
year 1942 hour 2 minute 0 M.

4. Sex F 5. Color or race White  
6. (a) Single, ~~widowed~~, married, divorced SO  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Dec. 26 1874  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 25 1942 to April 4 1942  
that I last saw her alive on April 3 1942  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
67 3 9 \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace Sparta Ill.  
(City, town, or county) (State or foreign country)

Immediate cause of death Coccarina Peritid  
Due to Metastasis to Cervical Nodes  
Due to 55  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

11. Industry or business \_\_\_\_\_  
12. Name Charles C. Hyndman  
13. Birthplace Logan County Ohio  
(City, town, or county) (State or foreign country)  
14. Maiden name Julia Kerrigan  
15. Birthplace New York N.Y.  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations Recurrent Carcinoma  
Of autopsy no  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Dr. Chas. E. Hyndman, Broth  
(b) Address 3720 Washington  
17. (a) Sparta, Ill. (b) Date thereof 4/6/42  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Sparta, Ill.  
18. (a) Signature of funeral director Albert H Hoppe  
(b) Address 4700 Washington  
19. (a) Apr 5 1942 (b) J. F. Bredbeck  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) no  
(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?  
no  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 11  
23. Signature W. E. Lightner (M.D. or other) M.D.  
Address 3720 Washington Date signed Apr 4 42

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

MOTHER FATHER

Removal

**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

*J. G. Sullivan*

Licensed Embalmer No. *1122*

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.**