

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **402**  
Registrar's No. **590**

Registration District No. **318** 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:  
**BETHESDA HOSPITAL**  
(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 **MISSOURI** (b) County **000**  
(c) City or town **ST. LOUIS** **1218**  
(If outside city or town limits, write "RURAL") **918**  
(d) Street No. **4210 HUNT AV.**  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country **0**

3. (a) PRINT FULL NAME **THOMAS DOYLE HAYES**  
3. (b) If veteran, name war **NO** 3. (c) Social Security No. **NO**  
4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **INFANT**  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **JULY 5 1943**  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Jan** day **18**  
year **1944** hour \_\_\_\_\_ minute **45 P.** M.  
21. I hereby certify that I attended the deceased from **1-17-44**  
\_\_\_\_\_, 19\_\_\_\_, to **1-18-44**, 19\_\_\_\_;  
that I last saw him alive on **1-18-44**, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

8. AGE: Years \_\_\_\_\_ Months **6** Days **13** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace **ST. LOUIS MO. 0**  
(City, town, or county) (State or foreign country)  
10. Usual occupation **INFANT**

Immediate cause of death **Enteritis** **8 d's**  
Due to **?**  
Due to **119**  
Other conditions **Severe acidosis** **2 d's**  
(Include pregnancy within 3 months of death)

11. Industry or business \_\_\_\_\_  
12. Name **EDWIN HAYES**  
13. Birthplace **ARKANSAS**  
(City, town, or county) (State or foreign country)  
14. Maiden name **EVA DORROUGH**  
15. Birthplace **ARKANSAS**  
(City, town, or county) (State or foreign country)  
16. (a) Informant **Mr. Edwin Hayes**  
(b) Address **4210 Hunt av**  
17. (a) **Buried** (b) Date there **JAN 19 1944**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **New St. Marcella Cem**  
18. (a) Signature of funeral director **E. J. Schuur**  
(b) Address **3125 Lafayette av**  
19. (a) **1944** (b) **J. F. Brubaker**  
(Date received local registration) (Registrar's signature)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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) \_\_\_\_\_ (Means of injury)  
23. Signature **W. D. Orley** (M. D. or \_\_\_\_\_)  
Address **4660 Maryland** Date signed **1-19-44**

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

36872

**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.....

*Joe B. Kollmer*

.....  
Licensed Embalmer No.....

P. O. Address.....

*4074*

**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.**