

U.S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **29410**  
Registrar's No. **7685**

**FILED SEP 18 1944**

**1003**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

**1. PLACE OF DEATH:**

(a) County \_\_\_\_\_  
 (b) City or town Saint Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Saint Louis Maternity Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 5 Hrs. 10 Min.  
(Specify whether)  
 In this community \_\_\_\_\_  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County 000  
 (c) City or town Saint Louis  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 5319 Penn Avenue  
Penny Branch (rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Infant Male Hayman

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race Negro  
 6. (a) Single, widowed, married, divorced 0  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 1, 1944  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month July day 1  
 year 1944 hour 12:0 minute 30 A.M.

21. I hereby certify that I attended the deceased from July 1 2 30 AM, 1944 to July 1 11 30 AM, 1944  
 that I last saw him alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
				<u>5</u> hr. <u>10</u> min.

Immediate cause of death Prematurity

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

9. Birthplace Saint Louis, Missouri 0  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER {  
 12. Name Robert B. Hayman  
 13. Birthplace Saint Louis, Missouri 0  
(City, town, or county) (State or foreign country)  
 14. Maiden name Lafay Williams  
 15. Birthplace Little Rock, Arkansas 1  
(City, town, or county) (State or foreign country)

16. (a) Informant Saint Louis Maternity  
 (b) Address 630 So. Kingshighway

17. (a) Burial (b) Date thereof AUG 31 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place; burial or cremation Anatomical Home

18. (a) Signature of funeral director W. Preston Washburn  
 (b) Address 3500 Butler West 7 Path

19. (a) SEP 8 1944 (b) J. J. Bradlock  
(Date received official registration) (Registrar's signature)

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 J. J. Bradlock (M. D. or other) MD  
 Address 630 So. Kingshighway Date signed 8/25/44

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

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7685

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**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 with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**