No. 2
—8-43
5-17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 3 1945

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4387

Primary Registration District No. 1003

Registrar's No. 1385

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: Mo. Baptist Hospital (If not in hospital or institution, write street number or location)

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

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis, (If outside city or town limits, write "RURAL") 10 000 17 9

(d) Street No. 4140 Lexington Ave (If rural, give location)

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

If yes, name country O

3. (a) PRINT FULL NAME John J. Hyland

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male C

5. Color or race White

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

6. (b) Name of husband or wife Dorothy Hyland

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

7. Birth date of deceased March 22 1883 (Month) (Day) (Year)

8. AGE: Years 61 Months 10 Days 18 If less than one day hr. min.

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

10. Usual occupation Merchant

11. Industry or business

MOTHER FATHER

12. Name Patrick Hyland

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

14. Maiden name Bridget Curran

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

16. (a) Informant Dorothy Hyland

(b) Address 4140 Lexington Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/45 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Stroot - Carroll

(b) Address 4600 Natural Bridge Ave

19. (a) FEB 12 1945 (Date received local registrar) (b) J. Breeden (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb, day 10 year 1945 hour 3;15 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 Lobar Pneumonia Duration

Fracture of left leg Scalp laceration when he big some [illegible] while crossing the street and was struck by an automobile being driven by one William [illegible] in front of 4125 West Rotterdam

Other conditions a Pond around 12:20 Am (Include pregnancy within 3 months of death)

Jan 14, 1945 170

Major findings:

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 Jan 14 1945

(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 place, in public place? Accident (Specify type of place)

While at work (e) Means of injury As above

23. Signature Patrick E. Taylor (M. D. or other) Dep Cor

Address Date signed 2/12/45

(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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Sheldon Collier

Licensed Embalmer No. 3382

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.