

FILED APR 27 1945

Registration District No. **318**

Primary-Registration District No. **1003**

Registrar's No. **3390**

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:
5150 River View Blvd.
(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: **Mo.** (b) County: _____
(c) City or town: **St. Louis,**
(If outside city or town limits, write "RURAL")
(d) Street No.: **5150 River View Blvd.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Edward J. Hynes**

3. (b) If veteran, name war: _____ 3. (c) Social Security No.: _____

4. Sex: **Male** 5. Color or race: **Wht.** 6. (a) Single, widowed, married, divorced, wid.: **2 divorced Wid.**
6. (b) Name of husband or wife: **Mary Hynes** 6. (c) Age of husband or wife if alive: _____ years
7. Birth date of deceased: **Sept. 17 1874**
(Month) (Day) (Year)

8. AGE: Years: **70** Months: **6** Days: **27** If less than one day: _____ hr. _____ min.

9. Birthplace: **St. Louis, Mo.** (City, town, or county) (State or foreign country)

10. Usual occupation: **Retired**

11. Industry or business: _____

12. Name: **John Hynes**
13. Birthplace: **Ireland** (City, town, or county) (State or foreign country)
14. Maiden name: **Catherine Loftus**
15. Birthplace: **Kentucky** (City, town, or county) (State or foreign country)

16. (a) Informant: **Edward J. Hynes**
(b) Address: **5150 River View Blvd.**

17. (a) **Burial** (b) Date thereof: **4/17/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: **Old S.S. Peter & Paul**

18. (a) Signature of funeral director: **Wm E. Moydell**
(b) Address: **1926 Allen Ave**

19. (a) **APR 17 1945** (b) **J. F. Bedeak**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **14**
year **1945** hour **10** minute **A.** M.

21. I hereby certify that I attended the deceased from **9/25/44** 19____ to **April 14** 19____;
that I last saw him alive on **April 10** 19____
and that death occurred on the date and hour stated above.

Immediate cause of death: **Cancer Lung**

Due to: _____

Due to: _____

Other conditions: _____
(Include pregnancy within 3 months of death)

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 injury)
(c) Means of injury: _____

23. Signature: **Chas. Miller** (Mr. D. or _____)
Address: **419 Humboldt** Date signed: **4/16/45**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

CC
17
9

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 me
....., Registered Apprentice No.
working under my personal supervision.

Signed David M. Davis
Licensed Embalmer No. 3741
P.O. Address 1926 Allen av

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.