S. No. 2
M—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 25 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 31930

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8971

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: 4515 THOLOZAN AVE
(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 MO (b) County
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 4515 THOLOZAN AVE
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ROBERT R. HAINES
3. (b) If veteran, name war NO
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife ANNA
6. (c) Age of husband or wife if alive 59 years
7. Birth date of deceased DEC (Month) 6 (Day) 1876 (Year)

8. AGE: Years 68 Months 10 Days 10 If less than one day hr. min.

9. Birthplace ST. LOUIS (City, town, or county) MO (State or foreign country)
10. Usual occupation CAPTAIN
11. Industry or business ST. LOUIS FIRE DEPT
FATHER 12. Name THOMAS HAINES
13. Birthplace ST. LOUIS (City, town, or county) MO (State or foreign country)
MOTHER 14. Maiden name ELIZABETH EWALD
15. Birthplace ST. LOUIS (City, town, or county) MO (State or foreign country)
16. (a) Informant ANNA HAINES
(b) Address 4515 THOLOZAN AVE
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-19-45 (Month) (Day) (Year)
(c) Place: burial or cremation NEW ST PETER PAUL
18. (a) Signature of funeral director KRIEGSHAUSER
(b) Address 4228 SO. KINGSHIGHWAY
19. (a) OCT 17 1945 (Date received local registrar) (b) J. F. Biedeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT day 16 year 1945 hour 7.05 AM minute M.
21. I hereby certify that I attended the deceased from Aug 15, 1945 to Oct 16, 1945, that I last saw him alive on Sept 16, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Cardiac Dilatation — Duration 1 da
Due to: Chronic Myocarditis — 1 yr
Due to: Arteriosclerosis — 8 yrs
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.

22. If death was due to external causes, fill in the following:
(c) 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? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address 4724 Gravois Date signed Oct 16 1945

(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 Edwin D McDermott

Licensed Embalmer No. 3024

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.