

**FILED** DEC 12 1945

Registration District No. .... Primary Registration District No. **1003** Registrar's No. **10469**

**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:  
3942 Sullivan Ave.  
(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)

3. (a) PRINT FULL NAME Mary E. Hayes

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased June 18. 1861  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>84</u>	<u>5</u>	<u>13</u>	hr. _____ min. _____

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

10. Usual occupation At Home

11. Industry or business .....

MOTHER FATHER {  
 12. Name John A. Hayes  
 13. Birthplace Ireland (City, town, or county) (State or foreign country)  
 14. Maiden name Julia Burke  
 15. Birthplace Ireland (City, town, or county) (State or foreign country)

16. (a) Informant Joseph M. Hayes

(b) Address 3942 Sullivan Ave.

17. (a) Burial (b) Date thereof 12/4/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director [Signature]

(b) Address 2117 E. Grand Blvd.

19. (a) DEC 3 1945 J. F. Braddock  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County St. Louis  
 (c) City or town St. Louis  
(If outside city or town limits, write "RURAL.")  
 (d) Street No. 3942 Sullivan Ave.  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country .....

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Dec. 1 day 1  
 year 1945 hour 6 minute 50 A.

21. I hereby certify that I attended the deceased from June 25  
 1945 to Nov 30, 1945  
 that I last saw h. ee alive on Nov 20, 1945  
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Cardiac Dilatation  
 Due to Chronic Myo Carditis  
Chronic interstitial nephritis  
 Due to Arterio Sclerosis  
 Other conditions None  
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings:  
 Of operations .....  
 Of autopsy .....  
[Signature]

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) .....

(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) (e) Means of injury

23. Signature [Signature] (M. D. or other)  
 Address 4548 Francis Ave Date signed 12/2/45

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

Dr. H. G. Klemm  
80 5758 4548 Harris  
1-2

**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..... *Frank A. Moore* .....

Licensed Embalmer No..... *3041* .....

P. O. Address..... *2117 E. Green* .....

**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.**