

S. No. 2
OM-5-43
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **188919**

FILED JUN 13 1947 **318**

Registration District No.

Primary Registration District No.

1003

Registrar's No.

5459

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:
Homer G. Phillips
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 25 mins
(Specify whether
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2933 Thomas
(If rural, give location)
(e) Citizen of Foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Kathleen Hayden

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

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

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

7. Birth date of deceased 5 12 47
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
14 hr. 5 min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name Earl Bee Hayden

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

14. Maiden name Barbara Hindsman

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

16. (a) Informant Father M. Shevard, R.H.D.

(b) Address 2601 N. Whittier

17. (a) Anatomical Board Date thereof 5-15-47
(Month) (Day) (Year)

(c) Place: burial or cremation Washington

18. (a) Signature of funeral director W. Reister

(b) Address 3530 Rutledge

19. (a) JUN 2 1947 (Date received local registrar)
J. F. Brebeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 12
year 1947 hour 6 minute 30 P.M.

21. I hereby certify that I attended the deceased from 4:25 A.M.
5-12, 1947, to 6:30 P.M., 1947;
that I last saw her alive on 5-12-47, 19...
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity Duration

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 place) (e) Means of injury.....

23. Signature W. S. Sprinkle (M. D. or other) 5-13-47

Address 2601 N. Whittier Date signed.....

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

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.