

National Office of Vital Statistics
FILED NOV 21 1947 78172

State File No.

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **9707**

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:
ST. LOUIS CITY HOSPITAL #1 **0**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **37 years**
(Specify whether years, months or days)

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. **2518 W. University St**
(If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME **JOHN B. HAYES**

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

4. Sex **male** 5. Color or race **white**
 6. (a) Single, widowed, married, divorced **married**
 6. (b) Name of husband or wife **Ida Hayes**
 6. (c) Age of husband or wife if alive **64** years
 7. Birth date of deceased **August 30th, 1883**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	64	1	17 hr. min.

9. Birthplace **Fort Wayne Ind**
(City, town, or county) (State or foreign country)

10. Usual occupation **Shoe worker**

11. Industry or business.....
 12. Name **John Hayes**
 13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)
 14. Maiden name **Bridget Malone**
 15. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Ida Hayes**
 (b) Address **2518 W. University St.**

17. (a) **Burial** (b) Date thereof **10-21-47**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **St. Peters Cemetery**

18. (a) Signature of funeral director **Hy. Leidner U. Co.**
 (b) Address **2223 St. Louis Ave.**

19. (a) **OCT 20 1947** (b) **J. F. Bieleck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **17th**
 year **1947** hour **6:05** minute **P. M.**

21. I hereby certify that I attended the deceased from **10-12-47**
 to **10-17-47**
 that I last saw him alive on **10-17-47**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Arterio-sclerotic heart disease & pericarditis**
anemia, cerebral

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?.....
(Specify type of place)
 While at work?..... (e) Means of injury **no**

23. Signature **J. M. P. Langford, M.D.** (M. D. or other).....
 Address **1515 Lafayette** Date signed **10-18-47**

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

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

MOTHER FATHER

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 Rex Campbell

Licensed Embalmer No. 3881

P. O. Address 2223 St. Louis Ave

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.