

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3495

FILED FEB 14 1949

State File No. ....

S. No. 300  
V. 10.48

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3069 Registrar's No. 73

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

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>ST LOUIS</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RICHMOND HEIGHTS 5 DAY</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>WEBSTER GROVES</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. MARYS HOSPITAL</u>		d. STREET ADDRESS (If rural, give location) <u>435 ALMA AVE</u>	

3. NAME OF DECEASED (Type or Print) <u>SOLOMON HAYNES</u>	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 12-1949</u>
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Nov 4-1866</u>	9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>VEHICAL DEPARTMENT</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>RAILWAY EXPRESS</u>	11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>LEONIDAS HAYNES</u>	13b. MOTHER'S MAIDEN NAME <u>CYNTHIA PAYTE</u>	14. NAME OF HUSBAND OR WIFE <u>STELLA HAYNES</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <u>STELLA HAYNES</u>	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Jan. 5, 1949</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic C-V disease</u>		
	DUE TO (c) <u>93d</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>4201</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Jan 5, 1949, to Jan. 12, 1949, that I last saw the deceased alive on Jan 11, 1949, and that death occurred at 3<sup>00</sup> A. m., from the causes and on the date stated above.

23a. SIGNATURE <u>Melvin J. Huber M.D.</u> (Degree or title)	23b. ADDRESS <u>634 N. Grand (3)</u>	23c. DATE SIGNED <u>1-12-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	24b. DATE <u>JAN-14-1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>CALVARY</u>	24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY - MO</u>
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DATE REC'D BY LOCAL REG. <u>1-13-49</u>	REGISTRAR'S SIGNATURE <u>Thurmond V. ...</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>PARKER UNDERTAKING CO.</u>
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FEB 25 1949

*For Mr. Nelson  
New Haven, Conn.*

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed *Leslie Welch*

Licensed Embalmer No. *4395*

P. O. Address *Newton Grove 7*

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.