

FILED FEB 23 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6310

State File No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1136

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Missouri</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Youngstown</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Alexian Bro. Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>109 Westwood</u>	

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
<u>Rev. Peter Hyland</u>				<u>2-5-1949</u>

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>May 30, 1889</u>	9. AGE (In years last birthday) <u>59</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clergy</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME <u>Unknown</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE
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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)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <u>Alexian Bro. Hosp.</u>	ADDRESS <u>3933 S. Broadway</u>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Coronary Sclerosis</u> DUE TO (c)		
II. 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	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) m.	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 1-26, 1949 to 2-5, 1949, that I last saw the deceased alive on 2-5, 1949 and that death occurred at 6 pm, from the causes and on the date stated above.

23a. SIGNATURE <u>B. J. Mc Ginnis</u> (Degree or title)	23b. ADDRESS <u>16 Hampton Valley Place</u>	23c. DATE SIGNED <u>2/6/49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>2-6-1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Youngstown Ohio</u>	24d. LOCATION (City, town, or county) (State) <u>Youngstown Ohio</u>
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DATE REC'D BY LOCAL <u>FEB 6 1949</u>	REGISTRAR'S SIGNATURE <u>J. B. Lanaker</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Weick Bro. Und. Co.</u>	ADDRESS <u>2201 S. Grand Bl</u>
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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 James R. Deun
Licensed Embalmer No. 4527

P. O. Address 2201 S. Grand St.

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.