

FILED JUL 9 1949
44877-49

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21131

State File No.

BIRTH NO. # 75922 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 00 Registrar's No. 5827

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <i>Mo</i> b. COUNTY <i>ada</i>	
b. CITY: (If outside corporate limits, write RURAL and give town OR TOWN <i>St. Louis, Mo.</i>)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>St. Louis 17</i>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) <i>816 E. Seward</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>St. Louis City Hospital</i>			

3. NAME OF DECEASED (Type or Print) a. (First) <i>Baby</i> b. (Middle) c. (Last) <i>Haynes</i>			4. DATE OF DEATH (Month) (Day) (Year) <i>6 19 49</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>6-18-49</i>	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>St. Louis, Missouri</i>	
12. CITIZEN OF WHAT COUNTRY?					

13a. FATHER'S NAME <i>Paul Haynes</i>	13b. MOTHER'S MAIDEN NAME <i>Marion Tonella</i>	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 <i>M. Williams</i> ADDRESS <i>City Hospital</i>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Premature Birth</i>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 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) <i>159</i>
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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? <i>776X</i>
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22. I hereby certify that I attended the deceased from *6-18-49*, 19*49*, to *6-19-49*, 19*49*, that I last saw the deceased alive on *6-19-49*, 19*49*, and that death occurred at *9:30* m., from the causes and on the date stated above.

23a. SIGNATURE <i>Edward L. Washington MD</i> (Degree or title)	23b. ADDRESS <i>1515 Lafayette Avenue</i>	23c. DATE SIGNED <i>6-20-49</i>
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <i>JUN 30 1949</i>	24c. NAME OF CEMETERY OR CREMATORY <i>Anatomical Board</i>	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. <i>JUN 30 1949</i>	REGISTRAR'S SIGNATURE <i>J. B. Parater</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Rowland Mortuary Service</i> 4104 Manchester Ave.
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WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

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.