

FILED JAN 10 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43249

State File No. _____

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>607K</u>		Registrar's No. <u>04834</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>21</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>Ballwin, Mo.</u>		c. LENGTH OF STAY (In this place) <u>1 yr 2 mo</u>		3. CITY (If outside corporate limits, write RURAL and give township) <u>Bynumville, Mo.</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 31 49</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Pine Crest Nursing Home</u>				d. STREET ADDRESS (If rural, give location) <u>None</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary</u>		b. (Middle) _____		c. (Last) <u>Hayes</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 31 49</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>		8. DATE OF BIRTH <u>May 25, 1875</u>	
9. AGE (In years last birthday) <u>84</u>		IF UNDER 1 YEAR Months _____		IF UNDER 1 YEAR Days _____		IF UNDER 1 HR. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nil</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Michael Hayes</u>		13b. MOTHER'S MAIDEN NAME <u>Sara Kelly</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>no</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Pine Crest Nursing Home</u>		ADDRESS _____	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES DUE TO (b) <u>Chr Myocarditis</u> DUE TO (c) <u>Senility</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>33IX</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>33IX</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) _____			
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? _____			
22. I hereby certify that I attended the deceased from <u>10-30</u> , 19 <u>48</u> , to <u>12-31</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>12-31</u> , 19 <u>49</u> , and that death occurred at <u>7:10A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>A. F. Werlein M.D.</u> (Degree or title)				23b. ADDRESS <u>3707 Potoma</u>		23c. DATE SIGNED <u>12-31-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>1-1-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Don't Know</u>		24d. LOCATION (City, town, or county) (State) <u>Marceline Mo</u>	
DATE REC'D BY LOCAL REG. <u>1-1-50</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Dombke, M.D.</u>		25. FUNERAL DIRECTOR'S NAME AND ADDRESS <u>Rowland Mortuary Service Inc. 410A Manchester Ave. St. Louis 10, Mo.</u>			

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

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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 J. Allen Davis Jr

Licensed Embalmer No. 4053

P. O. Address D. Davis M.

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.