

FILED JAN 28 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 2543

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 593

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Childrens Hospital		d. STREET ADDRESS (If rural, give location) 1 5 6129 Wagner Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) Barbara	b. (Middle) Kay	c. (Last) Hadley	4. DATE OF DEATH (Month) (Day) (Year) Jan. 17, 1950
---	-----------------	------------------	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Dec. 10, 1948	9. AGE (In years last birthday) 1 1 8	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 HRS. Hours	IF UNDER 15 MIN. Min.
------------------	---------------------------	---	-----------------------------------	--	---------------------------	--------------------------	--------------------------	--------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.
---	-----------------------------------	---	--------------------------------------

13a. FATHER'S NAME Lawrence Hadley	13b. MOTHER'S MAIDEN NAME Christiana Ballard	14. NAME OF HUSBAND OR WIFE None
---------------------------------------	---	-------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Lawrence Hadley, 6129 Wagner	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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) <i>Congenital Cardiac Hypertrophy</i>		INTERVAL BETWEEN ONSET AND DEATH
	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 checked="" type="checkbox"/> NO <input 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) 7544
--	--	---

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?
--	--	----------------------------

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at 11:50 P. m., from the causes and on the date stated above.

22a. SIGNATURE <i>Cathel E. Taylor Cor</i>	(Degree or title) 3	22b. ADDRESS 1300 Clear	22c. DATE SIGNED 1-19-50
---	------------------------	----------------------------	-----------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 1-18-50	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Licking, Mo.
--	----------------------	------------------------------------	---

DATE REC'D BY LOCAL REG. JAN 19 1950	REGISTRAR'S SIGNATURE <i>J. B. Kasater</i>	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe, 4700 Washington Blvd.	ADDRESS
---	---	--	---------

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

2009

FFB 3 1950

---

---

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 Me

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

working under my personal supervision.

Student .....  
Student Embalmer

Signed E. Courville Remelius

Licensed Embalmer No. 4283

P. O. Address St. Louis, Mo.

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.