

FILED MAR 4 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

318

1003

State File No. 6275  
Registrar's No. 1690

BIRTH NO. 10671-50 REG. DIST. NO. PRIMARY REG. DIST. NO.

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) a. STATE <i>Mo.</i> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>St. Louis</i>		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>Fitzmin Desloye Hospital</i>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>St. Louis</i>	
3. NAME OF DECEASED a. (First) <i>Gerald</i> b. (Middle) <i>Thomas</i> c. (Last) <i>Haire</i>		d. STREET ADDRESS (If rural, give location) <i>6 4723 Green 15.</i>	
4. DATE OF DEATH (Month) (Day) (Year) <i>2 20 50</i>	5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>0</i>
8. DATE OF BIRTH <i>2-19-50</i>	9. AGE (In years last birthday) <i>0</i>	IF UNDER 1 YEAR Months <i>2</i> Days <i>7</i>	IF UNDER 24 HRS. Hour <i>7</i> Min.
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, Mo.</i>	12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME <i>John Thomas Haire</i>	13b. MOTHER'S MAIDEN NAME <i>Merle Laron Skaggs</i>	14. NAME OF HUSBAND OR WIFE	
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 ADDRESS <i>Merle Laron Haire</i>	
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Pre maturity</i> ANTECEDENT CAUSES <i>Atelectasis</i> DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS <i>New born Tetany</i>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <i>None</i>	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) <i>7625</i>	
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 <i>20 Feb</i> , 1950, to <i>21 Feb</i> , 1950, that I last saw the deceased alive on <i>20 Feb</i> , 1950 and that death occurred at <i>4:30 a.m.</i> , from the causes and on the date stated above.			
23a. SIGNATURE <i>H. G. Caixiere, M.D.</i> (Degree or title)		23b. ADDRESS <i>1325 South Grand</i>	23c. DATE SIGNED <i>21 Feb 50</i>
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24b. DATE <i>2-21-50</i>	24c. NAME OF CEMETERY OR CREMATORY <i>St. Matthew's</i>	24d. LOCATION (City, town, or county) (State) <i>St. Louis, Mo.</i>
DATE REC'D BY LOCAL REG. <i>FEB 21 1950</i>	REGISTRAR'S SIGNATURE <i>J. B. Foster</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Will Broz L. &amp; C. 2929 S. Jefferson</i>	

---

---

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.....

*Not Embalmed*

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.