

FILED OCT 27 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

318
1003
State File No. 8817
34944
8817

BIRTH NO.		REG. DIST. NO.	PRIMARY REG. DIST. NO.	Registrar's No.
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) St. Louis Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2019		
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital		d. STREET ADDRESS (If rural, give location) 7817A Water Street		
3. NAME OF DECEASED (Type or Print) a. (First) Jesse b. (Middle) Patrick c. (Last) Hyatt		4. DATE OF DEATH (Month) (Day) (Year) Oct. 17, 1950		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		8. DATE OF BIRTH Jan. 9, 1888
11. BIRTHPLACE (State or foreign country) Missouri		9. AGE (In years) (Month) (Day) (Year) 62		
13a. FATHER'S NAME Joseph Hyatt		13b. MOTHER'S MAIDEN NAME Mary Derooy		14. NAME OF HUSBAND OR WIFE (Deceased)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 49701166		17. INFORMANT'S SIGNATURE OR NAME John Burke, 7817A Water Street
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Larynx with metastases 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 Oct. 30, 1949		19b. MAJOR FINDINGS OF OPERATION Carcinoma of Larynx		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)
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? Fall
22. I hereby certify that I attended the deceased from 8/9, 1950, to 10/17, 1950, that I last saw the deceased alive on 10/17, 1950, and that death occurred at 9:25 P.M., from the causes and on the date stated above.				
23a. SIGNATURE Joseph W. West, M.D.		23b. ADDRESS 1515 Lafayette Av.		23c. DATE SIGNED 10/17/50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10/20/50		24c. NAME OF CEMETERY OR CREMATORY National Cemetery
24d. LOCATION (City, town, or county) (State) Jefferson Brks. Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Fendler Und., Co, 7420 Michigan Ave.		
DATE RECEIVED BY LOCAL REG. OCT 1 1950		REGISTRAR'S SIGNATURE J. B. Parater		

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

John M. Liguori

Signed.....
Student Embalmer

Licensed Embalmer No. *4343*

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.