

STANDARD CERTIFICATE OF DEATH

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (In this place) 3-WKS.		d. STREET ADDRESS (If rural, give location) 4404 Lindell Blvd.	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital			

3. NAME OF DECEASED (Type or Print) Dr. Robert	a. (First)	b. (Middle) F.	c. (Last) Hyland	4. DATE OF DEATH Dec. 14, 1950	(Month) (Day) (Year)
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5. SEX M.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M.	8. DATE OF BIRTH Mar. 6, 1886	9. AGE (In years last birthday) 64	# UNDER 1 YEAR 9	# UNDER 1 YEAR 8	# UNDER 1 MRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Michigan	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Michael Hyland	13b. MOTHER'S MAIDEN NAME Sophia Minogue	14. NAME OF HUSBAND OR WIFE Mrs. Genevieve Hyland
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes World War # I	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Mrs. Genevieve Hyland, 4404 Lindell Blvd.	ADDRESS
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Dissected liver</i>		
ANTECEDENT CAUSES			
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>a</i>			
DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Empygeal hemorrhage 3 wks Hepatic renal failure</i>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <i>Empygeal veins distended. Liver cont.</i>	20. AUTOPSY? YES <input checked="" 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>581.0</i>
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22. I hereby certify that I attended the deceased from *11/20/50* 19*50*, to *12/14/50* 19*50*, that I last saw the deceased alive on *12/13/50*, and that death occurred at *7:50 a.m.* from the causes and on the date stated above.

23a. SIGNATURE <i>[Signature]</i>	(Degree or title)	23b. ADDRESS <i>[Address]</i>	23c. DATE SIGNED <i>12/15/50</i>
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec. 16, 1950	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis MO.
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DATE REC'D BY LOCAL REG. DEC 15 1950	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>	ADDRESS 3840 Lindell Blvd.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

NOV 18 1953

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 *Thomas R. Fenwick*

Signed
Student Embalmer

Licensed Embalmer No. *3793*

P. O. Address *3840 Lindell*

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.