

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33014
8457

State File No.

FILED SEP 25 1952

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's 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 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 Danbury	
c. LENGTH OF STAY (in this place) 30 hrs.		8060	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mayfair Hotel St. Charles		d. STREET ADDRESS (If rural, give location) R. R. #4	

3. NAME OF DECEASED (Type or Print) Dr. E. R. Hays	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH Sept. 8 1952	(Month)	(Day)	(Year)
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 15, 1894	9. AGE (In years last birthday) 66	10 UNDER 1 YEAR Months	1 YEAR Days	10 UNDER 1 HRS. Hours	1 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dr. of medicine	10b. KIND OF BUSINESS OR INDUSTRY Doctor	11. BIRTHPLACE (State or foreign country) Falls City, Nebr.	12. CITIZEN OF WHAT COUNTRY? U. S.
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13a. FATHER'S NAME Unknown Hays	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Lillian Hays
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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 Lillian Hays	ADDRESS R. R. 4 Danbury, Conn.
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND 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>Cronary Thrombosis</i> 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	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4201
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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 1:28 P. M., from the causes and on the date stated above.

23a. SIGNATURE <i>Patrick E. Taylor Carson</i>	(Degree or title)	23b. ADDRESS 13th Clark	23c. DATE SIGNED 9/9/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 9/9/52	24c. NAME OF CEMETERY OR CREMATORY Falls City Cemetery	24d. LOCATION (City, town, or county) (State) Falls City, Nebr.
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DATE REC'D BY LOCAL REG. SEP 8 1952	REGISTRAR'S SIGNATURE <i>J. C. Smith</i>	25. FUNERAL DIRECTOR'S SIGNATURE Suedmeyer & Sons	ADDRESS 3934 N. 20th St.
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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 *Guastav W. Dittich* _____

Licensed Embalmer No. *4329* _____

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.