

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3201**
Registrar's No. **0049**

FILED JAN 28 1953

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 Missouri b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Missouri		c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		2249
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital			d. STREET ADDRESS (If rural, give location) 24 2811 Indiana		
3. NAME OF DECEASED (Type or Print) EDWARD		a. (First)	b. (Middle)	c. (Last) HAYNER	4. DATE OF DEATH (Month) (Day) (Year) JANUARY 2 1953
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH June 15, 1887	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY unknown	11. BIRTHPLACE (City and State or Foreign Country) Iowa		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Joseph Hayner		13b. MOTHER'S MAIDEN NAME Adele Wheelock		14. NAME OF HUSBAND OR WIFE single	
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 ADDRESS Lois Crabtree, 2811 Indiana		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Kremia ANTECEDENT CAUSES DUE TO (b) Arteriosclerosis DUE TO (c) Angerecton II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cirrhosis of the liver				INTERVAL BETWEEN ONSET AND 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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 446X			
22. I hereby certify that I attended the deceased from 12-28-52 , 19___, to 1-2-53 , 19___, that I last saw the deceased alive on 1-2-53 , 19___, and that death occurred at 5:10P m. , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Calvin H. Davidson M.D.			23b. ADDRESS 1515 Lafayette Avenue		23c. DATE SIGNED 1-3-53
24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 1-5-53	24c. NAME OF CEMETERY OR CREMATORY New St Marcus	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		
DATE REC'D BY LOCAL REG. JAN 5 1953	REGISTRAR'S SIGNATURE Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland Aker, 4104 Manchester		

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

STATEMENT BY LICENSED EMBALMER

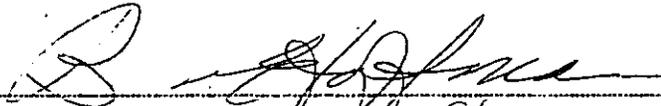
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed



Licensed Embalmer No. 7360

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.