

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

7643

No. 300  
10.48

State File No. \_\_\_\_\_  
Registrar's No. **1854**

FILED MAR 11 1953

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)<br>a. STATE <b>Missouri</b> b. COUNTY  |  |   |  |  |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Missouri</b>   |  | c. LENGTH OF STAY (In this place)   |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b> <b>2259</b> |  |  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis City Hospital</b>  |  | d. STREET ADDRESS (If rural, give location) <b>25 Stag Hotel - 5 No. 9th St.</b>  |  |   |  |  |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>PAUL</b>   |  | b. (Middle) <b>SANFORD</b>  |  | c. (Last) <b>HINSHAW</b>  |  |  |  |
| 4. DATE OF DEATH (Month) (Day) (Year)<br><b>FEBRUARY 2, 1953</b>  |  | 5. SEX <b>Male</b>  |  | 6. COLOR OR RACE <b>White</b>   |  |  |  |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widower</b>   |  | 8. DATE OF BIRTH <b>Dec. 3, 1899</b>  |  | 9. AGE (In years last birthday) <b>53</b>   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (City and State or Foreign Country) <b>Indiana</b>   |  |  |  |
| 13a. FATHER'S NAME <b>William Hinshaw</b>   |  | 13b. MOTHER'S MAIDEN NAME <b>Blanche Baylton</b>  |  | 14. NAME OF HUSBAND OR WIFE <b>Catherine (deceased)</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>   |  | 16. SOCIAL SECURITY NO. <b>Unknown</b>  |  | 17. INFORMANT'S SIGNATURE OR NAME <b>Hospital Record</b> ADDRESS  |  |  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.                                       |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute leukemia - lymphoblastic</b><br>ANTECEDENT CAUSES<br>DUE TO (b) _____<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (c) _____<br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>3 Pulmonary Tuberculosis</b> |  |   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| 19a. DATE OF OPERATION  |  | 19b. MAJOR FINDINGS OF OPERATION  |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21f. HOW DID INJURY OCCUR? <b>2040A</b>   |  |  |  |
| 22. I hereby certify that I attended the deceased from <b>1-28-53</b> , 19____, to <b>2-2-53</b> , 19____, that I last saw the deceased alive on <b>2-2-53</b> , 19____, and that death occurred at <b>5:35A m.</b> , from the causes and on the date stated above. |  |   |  |   |  |  |  |
| 23a. SIGNATURE (Degree or title) <b>John Will Wallace M.D.</b>  |  | 23b. ADDRESS <b>1515 Lafayette Avenue</b>   |  | 23c. DATE SIGNED <b>2-2-53</b>  |  |  |  |
| 24b. DATE <b>2-28-53</b>  |  | 24c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>  |  | 24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>                                       |  |  |  |
| DATE REC'D BY LOCAL REG. <b>FEB 17 1953</b>   |  | REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>   |  | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Rowland Mortuary Service</b> ADDRESS <b>1124 N. Chester Ave.</b>      |  |  |  |

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. \_\_\_\_\_

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.