

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31056**

FILED OCT 5 1953

BIRTH NO. **49816** REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **1038**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital		d. STREET ADDRESS (If rural, give location) 223 No. 21st Street	

3. NAME OF DECEASED (Type or Print) Frank	a. (First) Leon	b. (Middle)	c. (Last) Hayes	4. DATE OF DEATH (Month) (Day) (Year) Sept. 26-1953
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5. SEX Male	6. COLOR OR RACE negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH Aug. 9-1953	9. AGE (In years last birthday) 1	IF UNDER 1 YEAR 1 Months 17 Days	IF UNDER 11 WRS. 0 Hours 0 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant's not any	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Joseph, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Lawrence L. Hayes	13b. MOTHER'S MAIDEN NAME Sylvia M. Kirby	14. NAME OF HUSBAND OR WIFE None
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	17. INFORMANT'S SIGNATURE OR NAME Lawrence L. Hayes	ADDRESS 223 No. 21st St. St. Joseph, Mo.
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs 3 hrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Dehydration		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Malnutrition 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	19b. MAJOR FINDINGS OF OPERATION	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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **9-20, 1953**, to **9-26, 1953**, that I last saw the deceased alive on **9-26, 1953**, and that death occurred at **4:10 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Clement C. Montgomery	23b. ADDRESS St. Joseph Mo	23c. DATE SIGNED 9-28-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept. 28-1953	24c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph Mo.
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DATE REC'D BY LOCAL REG. Sept 29, 1953	REGISTRAR'S SIGNATURE Bethen M. Allison	485	25. FUNERAL DIRECTOR'S SIGNATURE Wm. H. Alexander	ADDRESS St. Joseph, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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 Wm H Alexander

Licensed Embalmer No. 4450

P. O. Address St. Joseph, 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.