

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33373**
Registrar's No. **8784**

FILED OCT 15 1953

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 8784		
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) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 50 yrs		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital				e. STREET ADDRESS (If rural, give location) 21 2814 Franklin Avenue 2219				
3. NAME OF DECEASED (Type or Print) a. (First) LANNIE b. (Middle) _____ c. (Last) HAYES			4. DATE OF DEATH (Month) (Day) (Year) Sept. 5, 1953					
5. SEX Male	6. COLOR OR RACE Col	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 17, 1876		9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unemployed		11. BIRTHPLACE (City and State or Foreign Country) Sedalia, Missouri		12. CITIZEN OF WHAT COUNTRY? _____		
13a. FATHER'S NAME Chas. Hayes		13b. MOTHER'S MAIDEN NAME Judy Hensley		14. NAME OF HUSBAND OR WIFE Gussie Hayes				
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. Unk		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Gussie Hayes 2814 Franklin Ave				
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic myocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Interstitial nephritis DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					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) 592 X				
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? _____				
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 11:30 P. m., from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) Patrick E. Taylor, Licensed			23b. ADDRESS 1300 Clark			23c. DATE SIGNED 9/10/53		
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE 9/13/53	24c. NAME OF CEMETERY OR CREMATORY Booker T. Washington		24d. LOCATION (City, town, or county) (State) Centerville Twp., Ill			
DATE REC'D BY LOCAL REG. SEP 10 1953		REGISTRAR'S SIGNATURE J. Earl Smith, MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS R. M. C. Green, 4060 Washington Ave				

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.....
Signature of Student Embalmer

Signed *Melvin E. Green*.....

Licensed Embalmer No. *442*.....

P. O. Address *St. Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.