

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33454**
8985
Registrar's No.

FILED OCT 15 1953

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

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 Missouri b. COUNTY			
b. CITY OR TOWN ST. LOUIS Mo		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN ST. LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5029 NEWPORT		e. STREET ADDRESS (If rural, give location) 15 5029 NEWPORT			
3. NAME OF DECEASED (Type or Print) a. (First) CHARLES W. b. (Middle) HYNEK c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) SEPT 15, 1953		
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	
8. DATE OF BIRTH JAN. 28 1887		9. AGE (In years last birthday) 71		IF UNDER 1 YEAR: Months Days IF UNDER 4 HRS: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE MAN		10b. KIND OF BUSINESS OR INDUSTRY CITY SANITARIUM		11. BIRTHPLACE (City and State or Foreign Country) MISSOURI	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13a. FATHER'S NAME CHARLES W. HYNEK		13b. MOTHER'S MAIDEN NAME CATHERINE SEDLAK	
14. NAME OF HUSBAND OR WIFE ANNA B. HYNEK		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 497-10-8218	
17. INFORMANT'S SIGNATURE OR NAME ANNA HYNEK		18. ADDRESS 5029 NEWPORT			
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) Carcinoma of Pancreas ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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) 157X	
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?	
22. I hereby certify that I attended the deceased from 8/1 1951 , to 9/15 1953 , that I last saw the deceased alive on 9/15 1953 , and that death occurred at 8:30 p. m. , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Harold A. Franklin M.D.		23b. ADDRESS 16 Hampton Valley		23c. DATE SIGNED 9/17/53	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE SEPT. 19 1953		24c. NAME OF CEMETERY OR CREMATORY S.S. PETER & PAUL CEM	
24d. LOCATION (City, town, or county) (State) ST. LOUIS Mo		25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kutis			
DATE REC'D BY LOCAL REG. SEP 17 1953		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.		ADDRESS 2906 Beavie	

444 Og Drive - Rm 5833
Hampton Village - PL 4600
Thurs - 12pm - 2pm

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 *Samuel Hill*

Licensed Embalmer No. *4347*

P. O. Address *2906*

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.