

FILED APR 29 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13533**
Registrar's No. **3585**

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) OR TOWN St. Louis		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"/>
c. LENGTH OF STAY (In this place) 66 yrs.		e. STREET ADDRESS (If rural, give location) 27 1011 N. Cardinal	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Charlie b. (Middle) c. (Last) Hayes			4. DATE OF DEATH (Month) (Day) (Year) March 25, 1954		
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) UNKNOWN	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NIL		10b. KIND OF BUSINESS OR INDUSTRY NIL		8. DATE OF BIRTH April 8, 1870	
11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri		9. AGE (In years last birthday) (Months) (Days) (Hours) (Min.) 83		12. CITIZEN OF WHAT COUNTRY? U. S. A.	

13a. FATHER'S NAME Abram Hayes		13b. MOTHER'S MAIDEN NAME ?		14. NAME OF HUSBAND OR WIFE ?	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <i>Natalia L. Brown</i>	
				ADDRESS Med. Dir. Of	

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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Mechanical Intestinal obstruction of large bowel.		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	

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) 570.5	
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 Mar. 15, 19 54 to Mar. 25, 19 54 that I last saw the deceased alive on Mar. 25, 19 54, and that death occurred at 8:40 pm., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>Earl G. Smith</i> M. D.		23b. ADDRESS 2601 N. Whittier		23c. DATE SIGNED 4/5/54	
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24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 4-30-54		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
				24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	

DATE REC'D BY LOCAL REG. APR 21 1954		REGISTRAR'S SIGNATURE <i>J. C. Smith</i> M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Rowland-Aker Mortuary Service	
				ADDRESS 1011 N. Cardinal	

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.....

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