

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24651

FILED JUL 26 1954

State File No. 24651
REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6538

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) St. Louis		c. LENGTH OF STAY (in this place) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		e. STREET ADDRESS (If rural, give location) 2527 N. Spring 2119	
3. NAME OF DECEASED (Type or Print) a. (First) Roosevelt b. (Middle) c. (Last) Hayes		4. DATE OF DEATH (Month) (Day) (Year) July 13, 1954	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 26-1907
9. AGE (In years last birthday) Months Days 46		11. BIRTHPLACE (City and State or Foreign Country) Ark	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Moulder		10b. KIND OF BUSINESS OR INDUSTRY Steel Mill	
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Carter	
13b. MOTHER'S MAIDEN NAME Cherrie Willis		14. NAME OF HUSBAND OR WIFE	
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. 492-0953452	
17. INFORMANT'S SIGNATURE OR NAME Jessie Bolden. 2124 Hickory		ADDRESS	
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 Carcinoma of left kidney with metastasis to lungs, adrenals, liver, mesenteric nodes and peritoneum INTERVAL BETWEEN ONSET AND DEATH Undt	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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.		Lung Abscess (right), Portal vein-thrombosis	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (Minute)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR 180X			
22. I, hereby certify that I attended the deceased from June 11, 1954, to July 13, 1954, that I last saw the deceased alive on July 13, 1954, and that death occurred at 5:50 a.m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) E. P. Williams M.D.		23b. ADDRESS 2601 N. Whittier	
23c. DATE SIGNED 7/13/54			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 7-17-54	
24c. NAME OF CEMETERY OR CREMATORY OAK DALE		24d. LOCATION (City, town, or county) (State) St. Louis County	
DATE REC'D BY LOCAL REG. JUL 16 1954		REGISTRAR'S SIGNATURE Carl Smith M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE W. J. ...		ADDRESS 2769 Chautauq	

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. 269

P. O. Address 2769 Chautauque

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.