

FILED JUL 26 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **24710**  
Registrar's No. **61411**

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 <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place) c. CITY OR TOWN <b>St. Louis</b> d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>1919 So Grand</b>		e. STREET ADDRESS (If rural, give location) <b>1919 So Grand</b>	
3. NAME OF DECEASED a. (First) <b>WILLIAM</b> (Type or Print)		b. (Middle) <b>T</b> c. (Last) <b>HYATT</b>	
4. DATE OF DEATH <b>July 5 1954</b>		5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Sept 15 1893</b>	
9. AGE (In years last birthday) <b>60</b>		10. MALE OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Doctor</b>	
11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis Mo</b>		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <b>Rolla B Hyatt</b>		13b. MOTHER'S MAIDEN NAME <b>Anna Knay</b>	
14. NAME OF HUSBAND OR WIFE <b>Margaret Hyatt</b>		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 <b>Margaret Hyatt 1919 So Grand</b>	
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) <b>Metastatic cancer in liver</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>from cancer of colon causing jaundice + portal obstruction</b> DUE TO (c) <b>obstruction</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION <b>Oct 1953</b>		19b. MAJOR FINDINGS OF OPERATION <b>Cancer of colon c metastases to liver</b>	
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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <b>153x</b>		22. I hereby certify that I attended the deceased from <b>Oct 1953</b> , to <b>July 5, 1954</b> that I last saw the deceased alive on <b>7-5, 1954</b> and that death occurred at <b>11:45 P.M.</b> , from the causes and on the date stated above.	
23a. SIGNATURE <b>Joseph E. Don Kessel MD</b>		23b. ADDRESS <b>634 N. Grand Blvd</b>	
23c. DATE SIGNED <b>7-6-54</b>		24a. BURIAL, CREMATION, REMOVAL (Specify)	
24b. DATE <b>July 8 54</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>	
24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>E. J. Schnur</b>	
25. FUNERAL DIRECTOR'S ADDRESS <b>3125 Lafayette</b>		DATE REC'D BY LOCAL REG. <b>JUL 7 1954</b>	
REGISTRAR'S SIGNATURE <b>Carl Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>E. J. Schnur</b>	

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.....  
*Joe B. Volmer*

Licensed Embalmer No. *4019*

P. O. Address *395 [unclear]*

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.