

FILED MAY 26 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **16718**BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **4332**

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 Saint Louis		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION De Paul Hospital		d. STREET ADDRESS (If rural, give location) 4229 Harris Avenue, 15, 10	
3. NAME OF DECEASED (Type or Print) MARTIN		a. (First) S.	b. (Middle) HYNES
c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) May 14th, 1955	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 28th, 1888
9. AGE (In years last birthday) 66		10. KIND OF BUSINESS OR INDUSTRY Bricklayer	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Michael Hynes	
13b. MOTHER'S MAIDEN NAME Catherine Minogue		14. NAME OF HUSBAND OR WIFE Helmie Hynes nee Elliott	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Helmie Hynes, 4229 Harris Avenue, 15,		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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio Sclerotic Heart Dis. ANTECEDENT CAUSES Arterio Sclerosis 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.	
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)	
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? 4200			
22. I hereby certify that I attended the deceased from March 17, 1953 , to May 14, 1955 , that I last saw the deceased alive on May 13, 1955 , and that death occurred at 6:10 P m., from the causes and on the date stated above.			
23a. SIGNATURE Chas. J. Jones		23b. ADDRESS 6000 W. Florissant	
23c. DATE SIGNED 5/16/55			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 5/17/55	
24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri	
DATE REC'D BY LOCAL REG. MAY 17 1955		REGISTRAR'S SIGNATURE Carl Smith, M.D.	
FUNDAL DIRECTOR'S SIGNATURE CALVIN F. FEUER		ADDRESS 4528 Natural Bridge Blvd., St. Louis, 15, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. 8 P.M. Mon.
File in City

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
Student Embalmer

Signed John A. Mlinar

Licensed Embalmer No. 4186

P. O. Address St Louis Mo

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 this body is not embalmed, fact should be so stated above.