

FILED DEC 18 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43166  
State File No. \_\_\_\_\_  
Registrar's No. **10978**

BIRTH NO. 72356-56 REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>Phelps</u> |   |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> |  | c. CITY OR TOWN <u>Newburg</u>   | d. Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. LENGTH OF STAY (in this place) <u>4 days</u>   |  | e. STREET ADDRESS (If rural, give location) <u>2810</u>  |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis Children's Hosp.</u>                     |  |  |   |

|   |                               |   |   |  |  |
|---|-------------------------------|---|---|--|--|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>Thomas</u> b. (Middle) <u>Alexander</u> c. (Last) <u>Hazen</u> |                               |   | 4. DATE OF DEATH (Month) (Day) (Year) <u>11-30-56</u>                     |  |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u> | 8. DATE OF BIRTH <u>9-7-56</u>  |  | 9. AGE (In years last birthday) IF UNDER 1 YEAR Months <u>2</u> Days <u>23</u> IF UNDER 12 HRS. Hours <u>0</u> Min. <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>             |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>                               | 11. BIRTHPLACE (City and State or Foreign Country) <u>Rolla, Missouri</u> |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 13a. FATHER'S NAME <u>Ralph C. Hazen</u>   |  | 13b. MOTHER'S MAIDEN NAME <u>Vivian Potter</u> |  | 14. NAME OF HUSBAND OR WIFE <u>None</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> |  | 16. SOCIAL SECURITY NO. <u>None</u>            |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>E. Johnston 500 S. Kings Highway</u> |  |

|  |  |   |  |                                  |  |
|--|--|---|--|----------------------------------|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)   |  | MEDICAL CERTIFICATION   |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Spinal muscular atrophy</u>  |  | ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> |  | DUE TO (b) _____                 |  |
| *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. |  | DUE TO (c) _____  |  | DUE TO (c) _____                 |  |
| II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>        |  |   |  | <u>356.2</u>                     |  |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 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) 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 11-26, 1956, to 11-30, 1956, that I last saw the deceased alive on 11-30, 1956, and that death occurred at 7:45 A m., from the causes and on the date stated above.

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 23a. SIGNATURE (Degree or title) <u>Barbara Jones, M.D.</u> |  | 23b. ADDRESS <u>Childrens Hospital</u> |  | 23c. DATE SIGNED <u>NOV 30 1956</u>                               |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>    |  | 24b. DATE <u>11-30-56</u>              |  | 24c. NAME OF CEMETERY OR CREMATORY                                |  |
|   |  |  |  | 24d. LOCATION (City, town, or county) (State) <u>Newburg, Mo.</u> |  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| DATE REC'D BY LOCAL REG. <u>NOV 30 1956</u> |  | REGISTRAR'S SIGNATURE <u>Carl Smith MD</u> |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe, 4700 Washington Blvd.</u> |  |
|---|--|--|--|--|--|

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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, ~~only~~ ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Etton R. Penelias*.....

Licensed Embalmer No. *428*

P. O. Address *St. Louis*.....

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.