

1. Health, Welfare, Public Service
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 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part 1 must be causally related. Coroner cannot certify to a death due to natural causes. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

HA 7-1 FILED FEB 25 1957

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER
 7103

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 273

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST LOUIS</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN <u>MARYLAND HEIGHTS</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>MARYLAND HEIGHTS</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>121 FRANK</u>			Length of stay in 1b <u>20 YRS</u>	d. STREET ADDRESS (If outside, give location) <u>121 FRANK</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JAMES WASHINGTON HALE</u>				First	Middle	Last	4. DATE OF DEATH Month <u>1</u> Day <u>29</u> Year <u>57</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 27 1915</u>		9. AGE (In years last birthday) <u>41</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Various</u>		11. BIRTHPLACE (City and state or country) <u>BERTRAND MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN WM HALE</u>				14. MOTHER'S MAIDEN NAME <u>SABIE MASSEY</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>489-10-3448</u>		17. INFORMANT Address <u>JESSE HALE 23 OLD DORSETT</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>							INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause first.		DUE TO (b) <u>Hypertension</u>		DUE TO (c) <u>Spicinity & Trauma</u>		<u>4201F</u>	Interval <u>5 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pt fell hitting head on sharp object in lavation</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>Overland St Louis MO.</u>				COUNTY STATE
21. I attended the deceased from <u>2/1956</u> to <u>1-29-57</u> and last saw her alive on <u>1-29-57</u> Death occurred at <u>5:10p.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>J. G. T. Bryan M.D.</u>				22b. ADDRESS <u>2573 Woodson</u>		22c. DATE SIGNED <u>Jan 30</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		23e. (State)		
<u>REMOVAL</u>	<u>2-1-57</u>	<u>DOGWOOD CEMETERY</u>		<u>DOGWOOD</u>		<u>MISSOURI</u>		
24. FUNERAL DIRECTOR ADDRESS <u>EARR HILLEMANN OVERLAND MO</u>			25. DATE RECD. BY LOCAL REG. <u>1-30-57</u>		26. REGISTRAR'S SIGNATURE <u>Hubert B. Donohue MD</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, or by, Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Earl Hillenian*
Licensed Embalmer No. 350

P. O. *Oakland 14*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.