

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29526

State File No. _____

7045

FILED AUG 30 1957

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | c. CITY OR TOWN St. John | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. LENGTH OF STAY (in this place) 4 days | | e. STREET ADDRESS (If rural, give location) 3297-Marshall Avenue | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Lukes Hospital | | | |

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|-------------------------------------|-------------------------|------------------------|-----------------------|---------------------------------------------------------------|
| 3. NAME OF DECEASED (Type or Print) | a. (First) Harry | b. (Middle) Lee | c. (Last) Hast | 4. DATE OF DEATH (Month) (Day) (Year) July 28, 1957 |
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|--------------------|-------------------------------|--------------------------------------------------------|---------------------------------------|-------------------------------------------|------------------------|----------------------|-----------------------|----------------------|
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH July 25, 1888 | 9. AGE (In years last birthday) 69 | IF UNDER 1 YEAR Months | IF UNDER 1 YEAR Days | IF UNDER 1 YEAR Hours | IF UNDER 1 YEAR Min. |
|--------------------|-------------------------------|--------------------------------------------------------|---------------------------------------|-------------------------------------------|------------------------|----------------------|-----------------------|----------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bicycle Repair | 10b. KIND OF BUSINESS OR INDUSTRY Repairing | 11. BIRTHPLACE (City and State or Foreign Country) Kansas City, Mo. | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
|----------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------|-----------------------------------------------|

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| 13a. FATHER'S NAME Oliver Hast | 13b. MOTHER'S MAIDEN NAME Unknown | 14. NAME OF HUSBAND OR WIFE |
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| 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 73 1130 | 17. INFORMANT'S SIGNATURE OR NAME Rose M. Hast | ADDRESS 3297-Marshall Ave. |
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| 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 | | INTERVAL BETWEEN ONSET AND DEATH undef. |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease | | |
| | ANTECEDENT CAUSES DUE TO (b) Islet cell tumor DUE TO (c) 420.0 | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death | | Islet cell tumor of pancreas, reported undef. | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
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| 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? |

22. I hereby certify that I attended the deceased from **July 24, 1957**, to **July 28, 1957**, that I last saw the deceased alive on **July 27, 1957**, and that death occurred at **12:20 a.m.**, from the causes and on the date stated above.

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| 23a. SIGNATURE Russell C. Oberst, M.D. | 23b. ADDRESS 4110 West Florissant Ave. | 23c. DATE SIGNED 7-29-57 |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 7-31-1957 | 24c. NAME OF CEMETERY OR CREMATORY Memorial Park | 24d. LOCATION (City, town, or county) (State) Normandy, Mo. |
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| DATE REC'D BY LOCAL REG. Jul 29 57 | REGISTRAR'S SIGNATURE J. Carl Smith M.D. | 25. FUNERAL DIRECTOR'S SIGNATURE Blumstein Bros. Inc. | ADDRESS 2501 Woodson Road Overland 14 Mo. |
|----------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------|

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 *Loron E Percy*.....

Licensed Embalmer No. *409*.....

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.