

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29533
STATE FILE NUMBER
7255

FILED AUG 30 1957

318

1003

Registration District No. Primary Registration District No. Registrar's No.

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, give TOWNSHIP only) OR TOWN ST LOUIS		c. CITY OR TOWN ST JOHNS 4201	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION PARKLANE HOSP		d. STREET ADDRESS 2956 RIDGEWAY	
3. NAME OF DECEASED (Type or print): JOHN STANLEY HAYS		4. DATE OF DEATH 8-3-57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 27 1876
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FIREMAN		9b. AGE (In years last birthday) 80	
10a. KIND OF BUSINESS OR INDUSTRY McDONNELL AIRCRAFT		11. BIRTHPLACE (City and state or country) MO SALEM DENT COUNTY	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JAMES FRANKLIN HAYS	
14. MOTHER'S MAIDEN NAME JULIA ANN GUMMY		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. UNKNOWN		17. INFORMANT MAUDE HAYS 2956 RIDGEWAY	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis, Chronic Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 422.2 DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			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 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 COUNTY STATE	
21. I attended the deceased from Oct 1856 to 8-3-57 and last saw him alive on 8-19-57 Death occurred at 1:15 a. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Clyde E. Kane M.D.		22b. ADDRESS 206 Walton	
22c. DATE SIGNED 8-3-57			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 8-3-57	
23c. NAME OF CEMETERY OR CREMATORY ROUND POUND CEMETERY		23d. LOCATION (City, town, or county) (State) SALEM MISSOURI	
24. FUNERAL DIRECTOR EARL HILLEMANN 9709 LACKLAND		25. DATE RECD. BY LOCAL REG. AUG 5 '57	
		26. REGISTRAR'S SIGNATURE Carl Smith MD	

(Licensed Embalmer's Statement on Reverse Side)

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 S. Hillman*

Licensed Embalmer No. *35*

P. O. Address *Orlando*

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.