

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-015895

STATE FILE NUMBER

4667

FILED MAY 8 1958

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

Health, Welfare, Public Service

300  
1-56

Use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Hospital		d. STREET ADDRESS 1017 N 18 Street	
3. NAME OF DECEASED (Type or print) First Iris Middle An Last Hayes		4. DATE OF DEATH Month 4 Day 23 Year 58	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 7. 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (City and state or country) St. Louis Mo	
13. FATHER'S NAME Chars Tatte		14. MOTHER'S MAIDEN NAME Myrtle Hayes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT Myrtle Hayes 1017 N 18. Street	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Intractable Cardiac Failure</i>			INTERVAL BETWEEN ONSET AND DEATH undet.
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 _____, Month _____, Day _____, Year _____			
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.)	
21. I attended the deceased from 4-16-58 to 4-23-58 and last saw her <del>face</del> alive on 4-16-58		22. DATE SIGNED 4-30-58	
22a. SIGNATURE <i>Paul Smith, M.D.</i> (Degree or title)		22b. ADDRESS 2601 Whittier Street	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 4/30/58	
23c. NAME OF CEMETERY OR CREMATORY Oakdale Cemetery		23d. LOCATION (City, town, or county) (State) 3900 Olive St. Lemay Mo	
24. FUNERAL DIRECTOR Boyd Bros 3706 Finney Ave		25. DATE RECD. BY LOCAL REG. APR 30 '58	
		26. REGISTRAR'S SIGNATURE <i>Paul Smith M.D.</i>	

(Licensed Embalmer's Statement on Reverse Side)

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 *Henry C. Williams*

Licensed Embalmer No. 4781

P. O. Address 1205 Wall

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.