

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023374

STATE FILE NUMBER

318

1003

6121

FILED JUN 27 1958

Registration District No.

Primary Registration District No.

Registrar

S. 300
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST. LOUIS Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION HOMER PHILLIPS		Length of stay in lb	d. STREET ADDRESS (If outside, give location) 1021 N. 18th ST. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Charles LAMONTE HAYES		First ALSO-KNOWN- Middle WITBURN- Last QUARTER) HAYES	4. DATE OF DEATH Month 6 - Day 11 - Year 58
5. SEX MALE	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 MAY 20, 1954
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 4 IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (City and state and country) ST. LOUIS, MO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Charles TATE		13b. MOTHER'S MAIDEN NAME Myrtle HAYES	
14. NAME OF HUSBAND OR WIFE		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. NONE		17. INFORMANT Address Myrtle HAYES - 1021 N. 18th ST	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBDURAL-HEMORRHAGE-2-RUPTURED-LIVER SUFFERED WHEN STRUCK BY CAR OPERATED BY ONE CHARLES HINSON (COL) IN PROJECT IN VICINITY OF 20th AND O FALLON ST. ABOUT 8:30 P.M. JUNE 11-1958 DUE TO (b) _____ DUE TO (c) ACCIDENT			INTERVAL BETWEEN ONSET AND DEATH
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 checked="" 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.) SEE ABOVE	
20c. TIME OF INJURY Hour 8:30 p.m. Month, Day, Year 6-11-58		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 STREET		20f. CITY, TOWN, OR LOCATION COUNTY STATE ST. LOUIS	
21. I attended the deceased from 853 P. to _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree of legibility) John In [Signature]		22b. ADDRESS 1300 Cass	
22c. DATE SIGNED 6/16/58		22d. (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 6/18/58	
23c. NAME OF CEMETERY OR CREMATORY DAKDALE CEM.		23d. LOCATION (City, town, or county) ST. LOUIS CO., MO.	
24. FUNERAL DIRECTOR ADDRESS W. ROBINSON & SONS. 2721 CASS AV		25. DATE RECD. BY LOCAL REG. JUN 16 '58	
26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D. S.P.			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

8127

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 *Leroy H. Barnister*

Licensed Embalmer No. *4523*

P. O. Address *4251 Washington*

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.