

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-027651

STATE FILE NUMBER

FILED AUG 11 1958 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2058

300
1-57

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>PINE LAWN</u> 4161 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>COUNTY HOSP</u>		Length of stay in lb <u>5 days</u>	d. STREET ADDRESS (If outside, give location) <u>6213 LEXINGTON</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Hutchings</u> <u>William Dewey Hutchings</u>			4. DATE OF DEATH Month Day Year <u>8-5-58</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>MAY 14 - 1898</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AMBULANCE ATT.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Attendant</u>	11. BIRTHPLACE (City and state or country) <u>CARLINVILLE, ILLINOIS</u>
13a. FATHER'S NAME <u>WALTER HUTCHINGS</u>		13b. MOTHER'S MAIDEN NAME <u>EMMA SANDERS</u>	14. NAME OF HUSBAND OR WIFE <u>ANITA HUTCHINGS</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>489-18-8784</u>	17. INFORMANT Address <u>MRS. ANITA HUTCHINGS 6213 LEXINGTON</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>Subarachnoid Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>443X</u>			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 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 a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <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 <u>8-1-58</u> to <u>8-5-58</u> and last saw him <u>here</u> live on <u>8-5-58</u> Death occurred at <u>6:55</u> A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Gene H. Page M.D.</u>		22b. ADDRESS <u>601 S. Brentwood, Clayton, Mo.</u>	22c. DATE SIGNED <u>8-5-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>AUG. 8-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. PETERS</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS COUNTY, Mo.</u>
24. FUNERAL DIRECTOR <u>L. B. Tanner</u>		ADDRESS <u>6107 Nat. Bldg.</u>	25. DATE RECD. BY LOCAL REG. <u>8-6-58</u>
		26. REGISTRAR'S SIGNATURE <u>Nesbert R. Drake M.D.</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Corrected by affidavit 9/30/58

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.

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

John S. Donnelly

Licensed Embalmer No. *4124*

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.