Health, & Welfare Public Service

C

S. 300 1-57

19

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-034307
STATE FILE NUMBER

FILED OCT 3 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9141

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST.LOUIS,MO. Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 25 ST.LOUIS. CITY HOSP. #1. Length of stay in 1b: 7/59

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY:
c. CITY OR TOWN: ST. LOUIS Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 4555 GRAVOIS Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Sarah Middle: Last: HAYHURST

4. DATE OF DEATH: Month SEPT. Day 19, Year 1958

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: DEC 5, 1879

9. AGE (In years last birthday): 78 IF UNDER 1 YEAR: Months, Days IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AT HOME

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): ST. LOUIS, MO.

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: BENJAMIN OBER

13b. MOTHER'S MAIDEN NAME: NOT KNOWN

14. NAME OF HUSBAND OR WIFE: DECEASED

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: ELIZABETH POLLOCK Address: 4555 GRAVOIS

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic lymphatic leukemia. — INTERVAL BETWEEN ONSET AND DEATH: unk.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 204.0
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 ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 8/31/58, to 9/19/58 and last saw her/him alive on 9/19/58
Death occurred at 9:15 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Jean A. Chapman, M.D. (Degree or title)

22b. ADDRESS: 1515 LAFAYETTE AVE

22c. DATE SIGNED: 9/20/58

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE: 9/23/1958

23c. NAME OF CEMETERY OR CREMATORY: NEW PICKER CEMETERY

23d. LOCATION (City, town, or county) (State): ST. LOUIS, MO.

24. FUNERAL DIRECTOR: J L ZIEGENHEIN & SONS ADDRESS: 7027 GRAVOIS

25. DATE RECD. BY LOCAL REG.: SEP 23 '58

26. REGISTRAR'S SIGNATURE: J Carl Smith MD MDB

(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 [signature]

Licensed Embalmer No. 486

P. O. Address St Louis Mo

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.