

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-042518

STATE FILE NUMBER

FILED DEC 1 1958 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3091

3. 300  
1-57

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| 1. PLACE OF DEATH<br>a. COUNTY <b>ST LOUIS</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>ST LOUIS</b> |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>CLAYTON</b>                  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <b>CLAYTON 4442</b><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                     |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>505 N BEMISTON</b> |  | Length of stay in 1b<br><b>5 YRS</b>  | d. STREET ADDRESS (If outside, give location)<br><b>505 N BEMISTON</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|--|--|--|--|--|--|
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>MARY CLEMENTINE HAYES</b> |  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>NOV 25 1958</b> |  |  |  |
|--|--|--|--|--|--|--|

|                         |                                  |   |  |  |                              |                                |
|-------------------------|----------------------------------|---|--|--|------------------------------|--------------------------------|
| 5. SEX<br><b>FEMALE</b> | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>DEC 12 1859</b> | 9. AGE (In years last birthday)<br><b>98</b> | FUNDER 1 YEAR<br>Months Days | IF UNDER 24 HRS.<br>Hours Min. |
|-------------------------|----------------------------------|---|--|--|------------------------------|--------------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if paired)<br><b>HOUSE WIFE</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>NONE</b> | 11. BIRTHPLACE (City and state or country)<br><b>LAKE CITY FLORIDA</b> | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b> |
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|---|---|--|
| 13a. FATHER'S NAME<br><b>CHARLES ROSS</b> | 13b. MOTHER'S MAIDEN NAME<br><b>MARTHA PASCHALL</b> | 14. NAME OF HUSBAND OR WIFE<br><b>JOHN HAYES</b> |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b> | 16. SOCIAL SECURITY NO.<br><b>NONE</b> | 17. INFORMANT<br><b>MRS L. E. NEWELL</b> Address <b>505 N BEMISTON</b> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebro-vascular Accident</b> |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hr</b>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   | DUE TO (b) <b>Arteriosclerotic cardiac vascular disease</b> |   |
|  | DUE TO (c) <b>422.1</b>                                     |   |
| 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?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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|---|--|--|
| 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<br>Hour Month, Day, Year<br>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 |
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21. I attended the deceased from **Oct 17 1958** to **Nov 25 1958** and last saw her/him alive on **Nov 20 1958**  
Death occurred at **11<sup>00</sup>** a m on the date stated above; and to the best of my knowledge, from the causes stated.

|   |                                       |                                     |
|---|---------------------------------------|-------------------------------------|
| 22. SIGNATURE (Degree or title)<br><b>Joseph E. Taylor M.D.</b> | 22b. ADDRESS<br><b>1617 Brentwood</b> | 22c. DATE SIGNED<br><b>11-25-58</b> |
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|   |                                  |   |   |
|---|----------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>REMOVAL</b> | 23b. DATE<br><b>Nov 26, 1958</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CALVARY CEMETERY</b> | 23d. LOCATION (City, town, or county) (State)<br><b>ST LOUIS MO</b> |
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| 24. FUNERAL DIRECTOR<br><b>STOCK MORTUARY</b> ADDRESS <b>889S BRENTWOOD CLAYTON</b> | 25. DATE RECD. BY LOCAL REG.<br><b>11-25-58</b> | 26. REGISTRAR'S SIGNATURE<br><b>Herbert R. Donker M.D.</b> |
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(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

21001 T2

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 Paul A. Wachtler

Licensed Embalmer No. 4787

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.