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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003039
STATE FILE NUMBER

FILED JAN 26 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 71

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis — Inside Limits Yes [x] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Bethesda Hospital — Length of stay in 1b 1 day

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY
c. CITY OR TOWN St. Louis — Inside Limits Yes [x] No [ ]
d. STREET ADDRESS (If outside, give location) 1425 Hodiamont Avenue — Reside on Farm Yes [ ] No [x]

3. NAME OF DECEASED (Type or print) First Middle Last: Claude Lester Hays

4. DATE OF DEATH Month Day Year: January 5, 1959

5. SEX: Male 0
6. COLOR OR RACE: White
7. MARRIED [x] NEVER MARRIED [ ] WIDOWED [ ] / DIVORCED [ ]
8. DATE OF BIRTH: April 6, 1898
9. AGE (In years last birthday): 60 — 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): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Retired 15years
11. BIRTHPLACE (City and state or country): Belfrade Missouri 0
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: Charles A. Hays
13b. MOTHER'S MAIDEN NAME: Martha Jane Ledford
14. NAME OF HUSBAND OR WIFE: Fay Hays

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO.: none
17. INFORMANT Address: Mrs. Fay Hays, 1425 Hodiamont Avenue.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Terminal Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Terminal Heart Dilitation — 1 day.
DUE TO (c) Emphysema — years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 527.1
19. WAS AUTOPSY PERFORMED? YES [x] NO [ ] 1

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 2-Oct-53, to 5-Jan-59, and last saw ~~her~~ him alive on 4-Jan-59.
Death occurred at 1 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): George Willgett M.D.
22b. ADDRESS: 4501a Manchester
22c. DATE SIGNED: 5-Jan-59.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Jan 7, 1959
23c. NAME OF CEMETERY OR CREMATORY: Sunlight Cemetery
23d. LOCATION (City, town, or county) (State): Belgrade, Missouri.

24. FUNERAL DIRECTOR ADDRESS: Shepard Funeral Home, 1167 Hamilton Ave.
25. DATE RECD. BY LOCAL REG.: JAN 5 '59
26. REGISTRAR'S SIGNATURE: J. Earl Smith, M.D. S.P.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 .....

Licensed Embalmer No. 4108

P. O. Address .....

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.