

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003720
STATE FILE NUMBER

FILED JAN 12 1959 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 33

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>4020 ST LOUIS COUNTY</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS CO. HOS.</u> Length of stay in 1b <u>2 WEEKS</u>		d. STREET ADDRESS (If outside, give location) <u>10965 BELLEFONTAINE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>ANDREW</u> Middle <u>HINES</u> Last <u>HINES</u>			4. DATE OF DEATH Month <u>1</u> Day <u>3</u> Year <u>59</u>		
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 11 1875</u>	9. AGE (In years at birthday) <u>83</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GROCCER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>GROCERY STORE</u>	11. BIRTHPLACE (City and state or country) <u>INDIANA</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
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13a. FATHER'S NAME <u>AUGUST HINES</u>	13b. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>MARY HINES</u>
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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) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NRK</u>	17. INFORMANT Address <u>10965 BELLEFONTAINE</u> <u>DR ARTHUR HINES</u>
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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>MYOCARDIAL INFARCTION.</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>CORONARY ATHEROSCLEROSIS.</u>	
	DUE TO (c) <u>GENERALIZED ATHEROSCLEROSIS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>DIABETES MELLITUS</u>		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.)
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20c. TIME OF INJURY .Hour .Month, Day, Year a.m. p.m.
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 12-21-58 to 1-3-59 and last saw ^{him} alive on 1-3-59
Death occurred at 10:22 PM. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>RB Holley</u> (Degree or title) <u>M.D.</u>	22b. ADDRESS <u>601 S. BRENTWOOD BL</u>	22c. DATE SIGNED <u>1-5-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>1/6/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LOCAL</u>	23d. LOCATION (City, town, or county) (State) <u>EMPORIA KANSAS</u>
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24. FUNERAL DIRECTOR ADDRESS <u>BUCHHOLZ MORT. 5967 W. FLORISSA HWY</u>	25. DATE RECD. BY LOCAL REG. <u>1-5-59</u>	26. REGISTRAR'S SIGNATURE <u>Herbert P. Donker M.D.</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300
1-57

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 *Joseph J. Buehler*
Licensed Embalmer No. *4551*
P. O. Address *J. Buehler*

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.