

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007193

STATE FILE NUMBER

2 1767

FILED MAR 10 1959

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

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1-57
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>Mo.</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS Mo.</i>		c. CITY OR TOWN <i>ST. LOUIS</i>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>8581 PARK LANE</i>		d. STREET ADDRESS (If outside, give location) <i>8581 PARK LANE</i>	
Length of stay in 1b		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>ELIZABETH HASTEY</i>			4. DATE OF DEATH Month Day Year <i>FEB. 16 1959</i>
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>AUG. 31 1879</i>
9. AGE (In years last birthday) <i>79</i>		10. F UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>WIDOW</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	11. BIRTHPLACE (City and state or country) <i>MISSOURI</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13a. FATHER'S NAME <i>HANS FINCK</i>	
13b. MOTHER'S MAIDEN NAME <i>SOPHIE PULS</i>		14. NAME OF HUSBAND OR WIFE <i>LUKE A. HASTEY</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT Address <i>LUKE HASTEY 8581 PARK LANE</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i>			INTERVAL BETWEEN ONSET AND DEATH <i>6 hrs</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Hypertension</i>			<i>3 yrs</i>
DUE TO (c) <i>420.1</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Mitral insufficiency</i>			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.) <i>none</i>	
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 Death occurred at <i>Jan 1957</i> to <i>Feb 17 1959</i> and last saw her alive on <i>Feb 17 1959</i> <i>3:05 P. m.</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>H. F. Miller M.D.</i>		22b. ADDRESS <i>2210 N. Broadway ST. LOUIS Mo.</i>	22c. DATE SIGNED <i>2-19-59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>FEB. 19, 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>NEW ST. MARCUS</i>	23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS Mo.</i>
24. FUNERAL DIRECTOR ADDRESS <i>Thomas Kuter 1906 Gravois</i>		25. DATE RECD. BY LOCAL REG. <i>FEB 19 '59</i>	REGISTRAR'S SIGNATURE <i>Earl Smith. M.D.</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

7-5780

6-7 P.M. 9 Dec. 1914

9-11 a.m. 9 Dec. 1914

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 Eleanor Poince

Licensed Embalmer No. 3403

P. O. Address Jennings 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.