Health, Welfare Public Service

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-007199
STATE FILE NUMBER

FILED FEB 24 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 1266

300
1-57
10
193
0

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 4453 Maffitt — Length of stay in 1b

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) 4453 Maffitt — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Percy Middle: Last: Hayes

4. DATE OF DEATH Month: 2 Day: 2 Year: 59

5. SEX M 2

6. COLOR OR RACE Col.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐

8. DATE OF BIRTH 3-25-84

9. AGE (In years last birthday) 74 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

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

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (City and state or country) Taylorville, Ga. 1

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Soloman Hayes

13b. MOTHER'S MAIDEN NAME Josephine Davis

14. NAME OF HUSBAND OR WIFE

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

16. SOCIAL SECURITY NO. 489-12-5198

17. INFORMANT A. Rev. Hayes-4317 N. Market St. Address

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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) Chronic Nephritis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chronic Myocarditis
DUE TO (c) 592X
INTERVAL BETWEEN ONSET AND DEATH
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 ☒ 2

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 ..... and last saw her/him alive on .....
Death occurred at 1140 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Patrick F. Taylor (Degree or title) Coroner
22b. ADDRESS 1300 Clark
22c. DATE SIGNED 2.5.59.

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 2-7-59
23c. NAME OF CEMETERY OR CREMATORY Greenwood Bemetery
23d. LOCATION (City, town, or county) St. Louis, Mo. (State)

24. FUNERAL DIRECTOR A.L. Beal Und.Co.-4303 Delmar ADDRESS
25. DATE RECD. BY LOCAL REG. FEB 5 '59
26. REGISTRAR'S SIGNATURE Noel Smith, M.D. M.D.

(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 .....

Licensed Embalmer No. .....

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.