

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015087

STATE FILE NUMBER

2 3713

FILED MAY 6 1959

Registration District No. Primary Registration District No. Street No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2614 Hickory St.		Length of stay in lb		d. STREET ADDRESS (If outside, give location) 2614 HICKORY	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>					

3. NAME OF DECEASED (Type or print) SEDDIE HAYES			4. DATE OF DEATH 4 - 13 - 59		
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 1890	9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home	10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (City and state or country) MENDHALL MISS.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME UNKNOWN			14. MOTHER'S MAIDEN NAME UNKNOWN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO.		16. SOCIAL SECURITY NO. --	17. INFORMANT Address ESSIE HORSKINS 2614 HICKORY		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH 3 mos
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) & Decompensated		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 443X		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.)
20c. TIME OF INJURY Hour Month, Day, Year 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

21. I attended the deceased from Feb 21-59 to Apr 13, 59 and last saw her alive on Apr 12 Death occurred at 7 am on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) Leon Smart MD	22b. ADDRESS 4069 E. Easton Ave	22c. DATE SIGNED Apr 13

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 4-18-59	23c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK	23d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY MO
24. FUNERAL DIRECTOR SWAN-McGHEE FUNERAL HOME	ADDRESS 619 Union	25. DATE RECD. BY LOCAL REG. APR 15 59	26. REGISTRAR'S SIGNATURE Leon Smart M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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MAY 7 1956

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was by me, or by Student Embalmer No. working under my personal supervision..

Student Signature of Student Embalmer

Signed Edward A. Flynn

Licensed Embalmer No. 44

P. O. Address 4202

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.