

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023020

STATE FILE NUMBER

2 5681

FILED JUL 1 1959

Registration District No. _____ Primary Registration District No. _____

Registrar No. _____

25
S. 300
1-57
692

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hosp.		d. STREET ADDRESS (If outside, give location) 4246a Humphrey	
Length of stay in lb 5 days		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JILL DEANNA HYDE			4. DATE OF DEATH Month Day Year June 13, 1959
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1959
9. AGE (In years last birthday) 0		IF UNDER 1 YEAR Months 0 Days 5	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) St. Louis Mo.
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Allen Hyde	
13b. MOTHER'S MAIDEN NAME Jacqueline Bertsch		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Allen Hyde		Address 4246a Humphrey	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature baby			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			776x
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 <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 _____ o.m. _____ p.m. _____ Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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 <u>6/9 7:35 P.M.</u> to <u>6/13</u> and last saw her alive on <u>6/13/59</u> Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Geo. Grant M.D. (Degree or title)		22b. ADDRESS 5521 S. Rdwy	
22c. DATE SIGNED 6/15/59		(State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 6/15/59	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivé Cemetery		23d. LOCATION (City, town, or county) Lemay Mo.	
24. FUNERAL DIRECTOR Fendler Und. Co. 7420 Michigan		25. DATE RECD. BY LOCAL REG. JUN 15 '59	
26. REGISTRAR'S SIGNATURE Neal Smith M.D.			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

Nov. 1, 1911
5-521 So. Broadway
Fl 3-1911 1-30P M.

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 *Not Embalmed*, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *W G Peterson*

Licensed Embalmer No. *3767*

P. O. Address *7420 Mich*

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.