

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027281

FILED VS AUG 13 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's **8 7171** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Length of stay in 1b 11 1/2 mo. c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Chronic Hosp. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri, b. COUNTY _____ c. CITY OR TOWN St. Louis, Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 8110 Pennsylvania. Reside on Farm Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harvey Middle F. Last Tayon.			4. DATE OF DEATH Month July Day 31, Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/8/1883	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (City and state or country) St. Louis, Missouri	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Frank Tayon		13b. MOTHER'S MAIDEN NAME Cormelius (Unk.)	
14. NAME OF HUSBAND OR WIFE Kate Tayon.		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No <input checked="" type="checkbox"/> None <input checked="" type="checkbox"/>			
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Kate Tayon 8110 Penna. St. Louis, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Coronary Thrombosis DUE TO (c) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH Old + New 8 mo. 11 1/2 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Terminal Bilateral Bronchopneumonia 24 hrs.					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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 _____ a.m. _____ p.m. Month, Day, Year _____		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 July 14, 1958 to July 31, 1959 and last saw her/him alive on July 31, 1959 Death occurred at 10.30 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) John W. Beckham, M.D.			22b. ADDRESS 5800 Arsenal		22c. DATE SIGNED 8/1/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Aug. 4, 1959	23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		23d. LOCATION (City, town, or county) Lamay, Missouri	
24. FUNERAL DIRECTOR ADDRESS C. Hoffmeister Mortuaries 7814 So. Broadway St. Louis, Mo.		25. DATE RECD. BY LOCAL REG. AUG 3 '59		26. REGISTRAR'S SIGNATURE Loan Smith. M.D.	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

M. J. B.

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed John J. Denne

Licensed Embalmer No. 4194

P. O. Address St. Lou

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