

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-034568**

**FILED OCT 13 1959**

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2552

INDEXED

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Clayton</u>		c. CITY OR TOWN <u>Kirkwood</u>	
Length of stay in 1b <u>14 D. Y. S.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis Co. Hoosp.</u>		d. STREET ADDRESS (If outside, give location) <u>216 Saratoga St.</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Will</u> Middle _____ Last <u>Haley</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>22</u> Year <u>1959</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 28 1904</u>	9. AGE (last birthday) <u>54</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>24</u>	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and state or country) <u>Wickliff K.Y.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Will Haley</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Lidell Haley</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>	16. SOCIAL SECURITY NO. <u>No. 319-12-3172</u>	17. INFORMANT <u>Lidell Haley Saratoga Sta</u>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		
DUE TO (b) <u>Pulmonary arrest and asphyxia</u>		
DUE TO (c) <u>Spinal anesthetic</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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
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21. I attended the deceased from <u>9-8-59</u> to <u>9-22-59</u> and last saw <u>her</u> him alive on <u>9-22-59</u>
Death occurred at <u>11:00</u> <u>A.</u> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Helene T. Hunt M.D.</u>	(Degree or title)	22b. ADDRESS <u>601 S. Brentwood, Clayton, Mo.</u>	22c. DATE SIGNED
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9/28, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Father Dickson Cem.</u>	23d. LOCATION (City, town, or county) <u>Greatwood</u>	(State) <u>Mo.</u>
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24. FUNERAL DIRECTOR <u>John W. Hemphill</u>	ADDRESS <u>408 S. Fillmore Ave</u>	25. DATE RECD. BY LOCAL REG. <u>9-25-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Mumfley M.D.</u>
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Kirkwood 22. Mo. (Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

APR 25 1960

**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 F. A. Green

Licensed Embalmer No. 2963

P. O. Address 4214 Delmar

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.