URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

60-008323

FILED VS MAR 14 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 1919 STATE FILE NUMBER

NDED

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

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: St. Louis
c. CITY OR TOWN: Affton — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 7213 Stonegate Dr. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: JOHN Middle: J. Last: HAYNES
4. DATE OF DEATH: Month: Feb. Day: 17 Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 9-19-1883
9. AGE (last birthday): 76
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HR: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auditor (Retired) Swift & Co.
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Unknown Haynes
13b. MOTHER'S MAIDEN NAME: Nellie Manger
14. NAME OF HUSBAND OR WIFE: Laura Mae Haynes
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.
17. INFORMANT: Laura Mae Haynes Address: 7213 Stonegate

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 pyelonephritis and uremia — INTERVAL BETWEEN ONSET AND DEATH: 4 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 600.0
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Colon, partial intestinal obstruction
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
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 2-20-54 to 2-17-60 and last saw her/him alive on 2-17-60
Death occurred at 9:40 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

BY AFFIDAVIT OF

22a. SIGNATURE (Degree or title): [illegible] MD
22b. ADDRESS: 4405 W. Pine
22c. DATE SIGNED: 2-18-60
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Feb. 20, 1960
23c. NAME OF CEMETERY OR CREMATORY: Resurrection Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis Co. Mo.
24. FUNERAL DIRECTOR: Kriegshauser ADDRESS: 4228 S. Kingshighway
25. DATE RECD. BY LOCAL REG.: FEB 18 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, 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

or by _____ Student Embalmer No. _____

working under my personal supervision.

Student _____ Signed _____
Signature of Student Embalmer

Licensed Embalmer No. 4533

P. O. Address _____

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