

U.S. DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-009386

FILED VS FEB 24 1960

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 316

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Manchester</u>		Length of stay in 1b <u>14 days</u>	c. CITY OR TOWN <u>St. Louis</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>Pine Crest Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>7136 Lanham</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Walker</u> Middle <u>Hughes</u> Last <u>Hughes</u>			4. DATE OF DEATH Month <u>Jan</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>July 3, 1893</u>	9. AGE (last birthday) <u>66</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER (RETIRED)</u>	10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	11. BIRTHPLACE (City and state or country) <u>Tennessee</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>William Hughes</u>	13b. MOTHER'S MAIDEN NAME <u>MATTIE BEAKLEY</u>	14. NAME OF HUSBAND OR WIFE <u>Ophelia</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>unk</u>	17. INFORMANT <u>Pine Crest Home Ballwin Mo</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>arterio sclerotic cardiac</u> <u>vascular disease</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>① Angina pectoris ② Atherosclerosis ③ Pulmonary embolism ④ Arteriohypertension</u>		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.) <u>none</u>
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20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u>	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.) <u> </u>	20f. CITY, TOWN, OR LOCATION <u> </u> COUNTY <u> </u> STATE <u> </u>
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21. I attended the deceased from Jan 15, 1960 to Jan 29, 1960 and last saw her alive on Jan. 26, 1960
Death occurred at 3:00 P.M. 1-29-60 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Clara M. Deane</u>	(Degree or title) <u> </u>	22b. ADDRESS <u>4308 E. 1st St. I.C.</u>	22c. DATE SIGNED <u>1-30-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>1/30/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LOCAL</u>	23d. LOCATION (City, town, or county) (State) <u>GIDEON Mo.</u>
24. FUNERAL DIRECTOR <u>Schradler Funeral Home</u>	ADDRESS <u>Ballwin</u>	25. DATE RECD. BY LOCAL REG. <u>1-30-60</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

Richard Bopp

Licensed Embalmer No.

4584

P. O. Address

Ballwin

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.