

**FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS MAR 25 1960**

**160-012691**  
 STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 3000**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>life</b>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <b>St. Louis Children's Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5211 Paulian Place</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Eleanor</b> Middle <b>Alicia</b> Last <b>Haynes</b>			4. DATE OF DEATH Month <b>3</b> Day <b>12</b> Year <b>1960</b>			
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5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5-22-53</b>	9. AGE (last birthday) <b>6 yrs</b>	IF UNDER 1 YEAR Months _____ Days _____	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) <b>child</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>child</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Theodore R. Haynes</b>	13b. MOTHER'S MAIDEN NAME <b>Eloise Watters</b>	14. NAME OF HUSBAND OR WIFE <b>none</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Theodore R. Haynes</b> Address <b>5211 Paulian</b>
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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: IMMEDIATE CAUSE (a) <b>Respiratory and cardiac arrest</b>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <b>Massive and extensive metastasis of tumor</b>		
DUE TO (c) <b>Wilms' tumor</b>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>3-1</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <b>180x</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) <b>180x</b>
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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 <b>St. Louis</b>	COUNTY <b>St. Louis</b>	STATE <b>Mo.</b>
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her alive on \_\_\_\_\_  
 Death occurred at **8:15** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Theodore R. Peterson, M.D.</b> (Degree or title)	22b. ADDRESS <b>500 So. Kingshighway</b>	22c. DATE SIGNED <b>3-12-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>3/15/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>
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24. FUNERAL DIRECTOR <b>Wm. Smith</b> ADDRESS <b>4019 Washington</b>	25. DATE RECD. BY LOCAL REG. <b>MAR 15 1960</b>	26. REGISTRAR'S SIGNATURE <b>Lois Smith, M.D.</b>
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Underwriter must take certificate to coroner's office per M.D. [Signature]

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 \_\_\_\_\_

Licensed Embalmer No. 4371

P. O. Address St Paul

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.