

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-024573

FILED VS JUL 12 1960

318

Primary Registration District No. 1003

Registrar's No. 6521

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Gallatin					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b 12 days		c. CITY OR TOWN Shawneetown		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last JAMES FRANKLIN HAYES				4. DATE OF DEATH Month Day Year JUNE 25 1960					
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 1/15/1910	9. AGE (last birthday) 50	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		11. BIRTHPLACE (City and state or country) Shawneetown, Ill.		12. CITIZEN OF WHAT COUNTRY U.S.		
13a. FATHER'S NAME Alonzo Hayes			13b. MOTHER'S MAIDEN NAME Jennie Barnett			14. NAME OF HUSBAND OR WIFE Lorena			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 311-01-6569		17. INFORMANT Address Lorena Hayes, Shawneetown, Ill.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACEREBRAL HEMORRHAGE							INTERVAL BETWEEN ONSET AND DEATH 7 DAYS		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) CONGENITAL ANEURYSM LEFT ANTERIOR CEREBRAL ARTERY									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 330x					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 JUNE 13, 1960 to JUNE 25, 1960 and last saw her/him alive on JUNE 25, 1960 Death occurred at 1:20 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) F. R. BRADLEY, M. D.				22b. ADDRESS BARNES HOSPITAL				22c. DATE SIGNED 6/26/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 6-27-60	23c. NAME OF CEMETERY OR CREMATORY Westwood Cemetery		23d. LOCATION (City, town, or county) Goldhill Twp., Ill.				
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, Inc., 4700 Washington Blvd.			25. DATE RECD. BY LOCAL REG. JUN 27 1960		26. REGISTRAR'S SIGNATURE Earl Smith, M.D. <i>m j b</i>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATE OF MISSOURI

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 Robert M. Murray

Licensed Embalmer No. 3749
P. O. Address St Louis

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.