

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-037041

FILED VS OCT 10 1960

INDEXED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2861 STATE FILE NUMBER

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) OR TOWN		Length of stay in lb <u>YRS</u>	c. CITY OR TOWN
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>10713 BOOTH</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>10713 BOOTH</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>MARTHA</u> Middle <u>ANNE</u> Last <u>HADLEY</u>			4. DATE OF DEATH Month <u>9</u> Day <u>27</u> Year <u>60</u>	
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-28-40</u>	9. AGE (last birthday) <u>20</u>	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)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>CASTLEMAN KAN.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
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13a. FATHER'S NAME <u>Joseph HADLEY</u>	13b. MOTHER'S MAIDEN NAME <u>RACHEL SMYTHE</u>	14. NAME OF HUSBAND OR WIFE
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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>NONE</u>	17. INFORMANT <u>JOSEPH HADLEY</u>	Address <u>10713 BOOTH</u>
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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) <u>EPILEPTIC SEIZURE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 MINUTES</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>MONGOLISM & EPILEPSIA</u>	<u>20 YRS</u>
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>MYOPATHIC SCOLIOSIS, CACHEXIA</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 _____ 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 9-15-43 to 8-24-46 and last saw her/him alive on 8-24-46
Death occurred at 12:00 NOON m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Edna Bannick, D.O.</u>	22b. ADDRESS <u>6651 ENRIGHT AVE</u>	22c. DATE SIGNED <u>9-28-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>9-29-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FEE FEE</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>
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24. FUNERAL DIRECTOR <u>Earl Hilleman</u>	ADDRESS <u>9709 BLACKLAND OVERLAND 1440</u>	25. DATE RECD. BY LOCAL REG. <u>9-28-60</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>
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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 Carl F. Hellemson

Licensed Embalmer No. 3501

P. O. Address Orland 1 V 2

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.