

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-048336

FILED VS. JAN 5 1961 317 Primary Registration District No. 500 Registrar's No. 3698 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lemay		Length of stay in 1b 6 Months		c. CITY OR TOWN Lemay		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION 224 E. Felton			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 224 East Felton		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sherri Middle N.M.I. Last Hayden				4. DATE OF DEATH Month December Day 22 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH June 4 1960	9. AGE (last birthday) 6 Months 18 Days	IF UNDER 1 YEAR Hours 12 Min.	IF UNDER 24 HR Hours 12 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME William Hayden			13b. MOTHER'S MAIDEN NAME Barbara Hayden			14. NAME OF HUSBAND OR WIFE None	
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. None		17. INFORMANT William Hayden 224 E. Felton			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronche - Pneumonia						INTERVAL BETWEEN ONSET AND DEATH 12 hours	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						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	
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 Dec 21 1960 to Dec 22 and last saw her him alive on Dec 22 at 6:30 AM Death occurred at 6:30 AM on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) John C. Crawford D.O.				22b. ADDRESS 9612 S. Broadway		22c. DATE SIGNED 12-22-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal BURIAL		23b. DATE December 24-60	23c. NAME OF CEMETERY OR CREMATORY Mt. Olive		23d. LOCATION (City, town, or county) Mt. Olive Rd. Lemay Mo.		23e. STATE Mo.
24. FUNERAL DIRECTOR C. Hoffmeister Mortuary ADDRESS 7814 S. Broadway				25. DATE RECD. BY LOCAL REG. 12-23-60		26. REGISTRAR'S SIGNATURE John C. Crawford M.D.	

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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed: Louis C. Hoffmann

Licensed Embalmer No. 3871

P. O. Address 7814 S. 1

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