

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

Primary Registration District No.

1003

Registrar's No.

7078-61-026898

STATE FILE NUMBER

AMENDED

Registration District No. **FILED AUG 8 1961**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		c. CITY OR TOWN <b>ST. LOUIS</b>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>3736<sup>9</sup> TEXAS AVE</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES FRANK HIATT</b>			4. DATE OF DEATH Month Day Year <b>JULY 30 1961</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</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>JULY 10, 1961</b>	9. AGE (last birthday) <b>20</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NO</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>ST. LOUIS MO.</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>JAMES F HIATT</b>		13b. MOTHER'S MAIDEN NAME <b>EDITH MAYER</b>	
14. NAME OF HUSBAND OR WIFE		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>JAMES HIATT</b>		Address <b>3726<sup>9</sup> TEXAS AVE</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Congenital heart disease</b>		
DUE TO (b) <b>(Transposition of aorta &amp; pulmonary artery</b>		
DUE TO (c) <b>&amp; absence of ventricular septum</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>754.2</b>		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 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.)
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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
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21. I attended the deceased from **July 10 to July 30** and last saw him alive on **July 30-61**  
Death occurred at **3 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Ralph Bergman</b> (Degree or title)	22b. ADDRESS <b>3203 S Grand</b>	22c. DATE SIGNED <b>7/31/61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>JULY 31 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>NEW ST. MARCUS CEM.</b>	23d. LOCATION (City, town, or county) <b>ST. LOUIS MO.</b>
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24. FUNERAL DIRECTOR <b>Thomas Kuttis 2906 Marois</b>	25. DATE REC'D. BY LOCAL REG. <b>JUL 31 1961</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith M.D.</b>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

*not*  
*to*

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed ~~by me~~,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *Eleana Province*

Licensed Embalmer No. *3403*

P. O. Address *906 Jarvis*

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.