

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-038670
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9992

FILED NOV 8 1961

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| 1. PLACE OF DEATH a. COUNTY | | 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 <u>St. Louis</u> | | Length of stay in 1b | c. CITY OR TOWN <u>St. Ann Mo.</u> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>De Paul Hospital</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>3500 Dixie</u> |
| | | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Hatley</u> Last <u>Hatley</u> | | | 4. DATE OF DEATH Month <u>October</u> Day <u>26</u> Year <u>1961</u> | | |
| 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>10/25/61</u> | 9. AGE (last birthday) — | IF UNDER 1 YEAR Months <u>40</u> Days <u>30</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u> | 11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>Troy Hatley</u> | | 13b. MOTHER'S MAIDEN NAME <u>Helen Moellmann</u> | | 14. NAME OF HUSBAND OR WIFE <u>Mr. Troy Hatley</u> | |
| 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>Troy Hatley 3500 Dixie St. Ann's, Mo.</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>Chromaturgy 1227</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3 wks</u> |
| DUE TO (b) <u>Acute hepato-splenic disease maternal</u> | | |
| DUE TO (c) <u>769.9</u> | | |

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| 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 | |
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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 <u>—</u> s.m. <u>—</u> p.m. <u>—</u> | 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 |
|--|--|------------------------------|--------|-------|

21. I attended the deceased from 10/25/61 to 10/26/61 and last saw her live on 10/26/61
Death occurred at 6/26/61 7 P on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <u>John R. Judy MD</u> | (Degree or title) | 22b. ADDRESS <u>11122 York Ferguson Rd</u> | 22c. DATE SIGNED <u>10/27/61</u> |
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| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) | 23b. DATE <u>10-28-61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cem.</u> | 23d. LOCATION (City, town, or county) <u>St Louis, MO</u> |
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| 24. FUNERAL DIRECTOR <u>White-Mullen Ferguson, MO</u> | ADDRESS | 25. DATE RECD. BY LOCAL REG. <u>OCT 27 1961</u> | 26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u> |
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DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
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 me,
or by *Jo Embalmer*, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *J. Muller*

Licensed Embalmer No. _____

P. O. Address _____

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.