

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **62-003884**

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **421**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>Life</b>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4374 Cook</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Kerry</b> Middle Last <b>Hayes</b>			4. DATE OF DEATH Month <b>1</b> Day <b>8</b> Year <b>62</b>			
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Unk. 1906</b>	9. AGE (last birthday) <b>abt. 55</b>	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) <b>Disabled chauffeur</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Sanitation Dept.</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>John Hayes</b>	13b. MOTHER'S MAIDEN NAME <b>Elizabeth Smothers</b>	14. NAME OF HUSBAND OR WIFE <b>Tennie Hayes</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Ethel Hunt, 4130 Margareta</b> Address
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Acidosis</b>		<b>Undet.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Intestinal Obstruction</b>	<b>Undet.</b>
	DUE TO (c) <b>Metastatic Carcinoma of Stomach</b>	<b>Undet.</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>151X</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
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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 a.m. 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 <b>1-3-62</b> to <b>1-8-62</b>	COUNTY <b>St. Louis Co., Mo.</b>	STATE
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21. I attended the deceased from **1-3-62**, to **1-8-62** and last saw <sup>xxx</sup>him alive on **1-8-62**  
Death occurred at **11:10** p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) <b>Edward Butler M.D.</b>	22b. ADDRESS <b>2601 N. Whittier Street</b>	22c. DATE SIGNED <b>1-9-62</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>1/12/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>
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24. FUNERAL DIRECTOR <b>Charles J. Gates, 4107 Finney</b> ADDRESS	25. DATE RECD. BY LOCAL REG. <b>JAN 10 1962</b>	26. REGISTRAR'S SIGNATURE <b>Neal Smith M.D.</b>
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RATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

STATEMENT BY LICENSED EMBALMER

**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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Gupton Swann

Licensed Embalmer No. 4580

P. O. Address 4107 Finney

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.