

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-009175
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 244

FILED MAR 7 1962	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BALLWIN</u> Length of stay in 1b <u>38 yrs.</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Pine Crest Nurseing Home</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS (If outside, give location) <u>1219a Montclair St</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <u>CARRIE HAYNES</u>	
4. DATE OF DEATH Month Day Year <u>Jan 16 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>
7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-30-1908</u>
9. AGE (last birthday) <u>54</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months <u>10</u> Days <u>1</u> Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>
11. BIRTHPLACE (City and state or country) <u>Marshall Co., Miss.</u>	12. CITIZEN OF WHAT COUNTRY <u>U S A</u>
13a. FATHER'S NAME <u>Samuel Weatherall</u>	13b. MOTHER'S MAIDEN NAME <u>Milinda Bailey</u>
14. NAME OF HUSBAND OR WIFE <u>Harvey Haynes</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. _____
17. INFORMANT Address <u>Harvey Haynes 1219a Montclair St</u>	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic-Cardio-vascular Disease</u> DUE TO (b) _____ DUE TO (c) <u>+221</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
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 SUICIDE HOMICIDE <u>NONE</u>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <u>June 1961 to 1-16-62</u> and last saw her alive on <u>1-11-62</u> <u>MSA</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
21. I attended the deceased from _____ Death occurred at _____	
22a. SIGNATURE (Degree or title) <u>Allen M. Kearney M.D.</u>	22b. ADDRESS <u>4308 E. Peter</u>
22c. DATE SIGNED <u>1-18-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Jan 22 1962</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co MO</u>
24. FUNERAL DIRECTOR ADDRESS <u>JAS H. RANDLE & SON 3133 Bell Ave</u>	25. DATE RECD. BY LOCAL REG. <u>1-18-62</u>
26. REGISTRAR'S SIGNATURE <u>John G. Murphy M.D.</u>	

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 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
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 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ
 USE BLACK INK OR TYPEWRITER RIBBON

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 Esther K. Harris

Licensed Embalmer No. 4458

P. O. Address 4181 Washington

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.