

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-032524

STATE FILE NUMBER

Registration District No. **318** Primary Registration District **1003** Registrar's No. **7781**

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1

2 *22*

3

4 *2*

5 *1*

6

7 *0*

8 *2*

9

10

11

12 *90-0*

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

FILED AUG 22 1962		1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b Life		c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2808 Rutger Street		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2808 Rutger Street Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle HAYNES Last			4. DATE OF DEATH Month August Day 5 Year 1962		
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/22/04	9. AGE (last birthday) 58	IF UNDER 1 YEAR Months 4 Days 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY National Lead Co.		11. BIRTHPLACE (City and state or country) St. Louis, Mo.	
12. CITIZEN OF WHAT COUNTRY U. S. A.		13a. FATHER'S NAME Michael Haynes		13b. MOTHER'S MAIDEN NAME Laura Britton	
14. NAME OF HUSBAND OR WIFE Henrietta Haynes		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.	
17. INFORMANT Martha Orton		Address 4877 Cote Brilliance			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart					INTERVAL BETWEEN ONSET AND DEATH Unknown
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 420.0 H					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Metastatic Pulmonary Malignancy from Primary in Pancreas				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 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 6-29-62 to 8-5-62 and last saw him alive on 8-4-62 Death occurred at 7:39 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (If free or title) N.E. Smith, M.D.			22b. ADDRESS 715 Union St. Louis		22c. DATE SIGNED 8-8-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8/9/62	23c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.		23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.	
24. FUNERAL DIRECTOR Charles J. Gates		ADDRESS 4107 Finney Ave.		25. DATE RECD. BY LOCAL REG. AUG 9 1962	
26. REGISTRAR'S SIGNATURE Loan Smith, M.D.					

USE BLACK INK OR TYPEWRITER RIBBON

MEDICAL CERTIFICATION

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. 665
working under my personal supervision.

Student Raymond Dickson Signed _____
Signature of Student Embalmer

Gupton Swan
Licensed Embalmer No. 4580

P. O. Address 4107 Finney Avenue

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.