

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-037047

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2523

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 20 1962

VS 300 Rev. 4/59

4002
2007

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9 175.0

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12 1245.0

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 <u>ST Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON MO</u>		c. CITY OR TOWN <u>WEBSTER GROVES</u>	
Length of stay in 1b <u>8 days</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>COUNTY HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>568 CANADAY</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Evelyn</u> Middle <u>MCCREE</u> Last <u>Hayes</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>27</u> Year <u>1962</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</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>17 DEC 1945</u>
9. AGE (last birthday) <u>37</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	11. BIRTHPLACE (City and state or country) <u>MOBILE ALABAMA</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>ABRAHAM HAYES</u>	
13b. MOTHER'S MAIDEN NAME <u>DORA MCCREE</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Dora McCree Hayes</u>		Address <u>568 Canaday</u>	
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>Carcinoma of Ovary</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 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			INTERVAL BETWEEN ONSET AND DEATH
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 <u>8-19-62</u> to <u>8-27-62</u> and last saw her alive on <u>8-27-62</u> . Death occurred at <u>12:55</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>J. J. Harris M.D.</u>		22b. ADDRESS <u>601 S. Brentwood, Clayton, Mo</u>	22c. DATE SIGNED <u>8-28-62</u>
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Sept 3, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Father Dickens</u>
23d. LOCATION (City, town, or county) <u>Crestwood Mo</u>		23e. (State) _____	
24. FUNERAL DIRECTOR <u>J. J. Paulsen</u>		ADDRESS <u>29 Euclid</u>	25. DATE RECD. BY LOCAL REG. <u>8-30-62</u>
26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>			

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 Madame P. Gaudere

Licensed Embalmer No. 4243

P. O. Address 32 Leugid
Habitat Rover Mo

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.