

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

4669 67 0020593
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4669

FILED MAY 25 1967

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in 1b		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>Incarinate Word Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>3623 Roswell ave.</u>	
Inside Limits 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 Middle Last <u>Frank A. Hayes</u>			4. DATE OF DEATH Month Day Year <u>May 14 1967</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-10-1900</u>	9. AGE (last birthday) <u>66</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer--Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sand & Material Co.</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U S A</u>		13a. FATHER'S NAME <u>Frank A. Hayes</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown Ginn</u>	
14. NAME OF HUSBAND OR WIFE <u>Frances</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>488-16-7226</u>	
17. INFORMANT <u>Howard Hayes</u>		Address <u>3623 Roswell ave.</u>			

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 <u>Indeterminate</u>
IMMEDIATE CAUSE (a) <u>Carcinoma of right lung--inoperable</u>		
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 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. <u>4.20 P.M.</u>	Month, Day, Year <u>5-11-67</u>		
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 <u>St. Louis</u>	COUNTY STATE
21. I attended the deceased from <u>7-27-66</u> to <u>5-11-67</u> and last saw <u>her</u> alive on <u>5-13-67</u> Death occurred at <u>4.20 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE <i>[Signature]</i>	(Degree or title) <u>M.D.</u>	22b. ADDRESS <u>2730 Watson Rd. 63139</u>	22c. DATE SIGNED <u>5-15-67</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>5-17-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Park Lawn Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>1600 Lemay, Ferry Rd. Lemay, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Hoffmeister Mortuaries Inc. 2814 S. Broadway</u>		25. DATE RECD. BY LOCAL REG. <u>MAY 15 1967</u>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

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 USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 SHOULD READ
 BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

MISSOURI

FIELD NO.

Dr. S. Schultz 2730 Watson Rd, MI-7-5150

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 Philip J. Casserly
Licensed Embalmer No. 4618

P. O. Address St. Louis, 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.

1:45 PM to 6 PM Mon