

S. No. 2
M-5-43
7. 5-17-39
I X36671

12253
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5223**
Registrar's No. **1943**

FILED MAR 6 1944 318
Registration District No. _____ Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 days** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **7314 S. Levee**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **Frank Hayes**
3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**
4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Emma Hayes** 6. (c) Age of husband or wife if alive **64** years
7. Birth date of deceased **August 13 1869**
(Month) (Day) (Year)
8. AGE: Years Months Days If less than one day
74 6 13 hr. min.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Feb.** day **26th**
year **1944** hour **5:50** minute **0** A. M.
21. I hereby certify that I attended the deceased from **Feb. 22nd**
1944, to **Feb. 26th**, 19 **44**
that I last saw him alive on **Feb. 26th**, 19 **44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Retropneumonococcal pneumonia**
Due to _____
Due to **Hb**
Other conditions (Include pregnancy within 3 months of death) _____
Major findings:
Of operations _____
Of autopsy **Refused**
Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

9. Birthplace **Franklin Co. Mo. 0**
(City, town, or county) (State or foreign country)
10. Usual occupation **None**
11. Industry or business _____
12. Name **Anderson Hayes**
13. Birthplace **Franklin Co. Mo. 0**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown 9**
(City, town, or county) (State or foreign country)
16. (a) Informant **Mrs. Mary Millerman**
(b) Address **7314 S. Levee**
17. (a) **Burial** (b) Date thereof **Feb. 29, 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Park Lawn Cem.**
18. (a) Signature of funeral director **C. Hoffmeister U.A.L.Co.**
(b) Address **7814 S. Broadway**
19. (a) **FEB 28 1944** (b) **J. T. Brueck**
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature **Frank J. Leung** (M, D, or other) **MD**
Address **1515 Lafayette** Date signed **2/26/44**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1700
1314
.07

of
of
of
of
of
of

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

Paul A. Shanley

Registered Apprentice No.

working under my personal supervision.

Signed *Paul A. Shanley*

Licensed Embalmer No. 3472

P. O. Address 48188 Broadway

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 this body is not embalmed, fact should be so stated above.