

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023579

FILED JUN 22 1959 Registration District No. 317 Primary Registration District No. 541 STATE FILE NUMBER 59-023579 Registrars No. 1550

1. PLACE OF DEATH a. COUNTY <u>St. Louis County</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</u>		c. CITY OR TOWN <u>Wellston 4311</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis County Hospital</u> Length of stay in lb <u>14 Days</u>		d. STREET ADDRESS (If outside, give location) <u>6150 Page Ave</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Milton</u> Middle <u>O</u> Last <u>DeHatre</u>			4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1959</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>2 Sept 1872</u>	9. AGE (In years <u>86</u> birthday)	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS Hours <u>0</u> Min. <u>0</u>
--------------------	-------------------------------	---	-------------------------------------	--------------------------------------	--	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
--	--	--	---

13a. FATHER'S NAME <u>John DeHatre</u>	13b. MOTHER'S MAIDEN NAME <u>Theresa Pressy</u>	14. NAME OF HUSBAND OR WIFE <u>Sylvia DeHatre Dec.</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>Unk.</u>	17. INFORMANT <u>Catherine Nagle</u> Address <u>2511 Sullivan Ave</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>PERITONITIS</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Past-Operative Condition</u>	
	DUE TO (c) <u>INTESTINAL OBSTRUCTION.</u>	
PART II. OTHER SIGNICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>CARCINOMA OF KIDNEY</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <u>6:35</u> a.m. <u>0</u> p.m. <u>0</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 Co, Mo.</u>
---	---	--	---

21. I attended the deceased from <u>5-22-59</u> to <u>6-6-59</u> and last saw her alive on <u>6-6-59</u> Death occurred at <u>6:35 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.	
---	--

22a. SIGNATURE <u>M.D. Bailey</u> (Degree or title) <u>M.D.</u>	22b. ADDRESS <u>601 S. Brentwood Blvd</u>	22c. DATE SIGNED <u>6/6/59</u>
---	---	--------------------------------

23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u> DATE <u>June 9 59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Ferdinand Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co, Mo.</u>
--	--	--

24. FUNERAL DIRECTOR <u>J.W. Clark</u> ADDRESS <u>F.H. 1125 Hodiament Ave.</u>	25. DATE RECD. BY LOCAL REG. <u>6-8-59</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D. JR.</u>
--	--	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Alfred J. Boedeker* .....

Licensed Embalmer No. *2667*

P. O. Address. *1125 Hudson*

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.