

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

42771

**1. PLACE OF DEATH**

County.....  
Township.....  
City *St. Louis, Mo* (No. *3073*) *Nabada ave*

Registration District No. **791**  
Primary Registration District No. **508**

File No.....  
Registered No. **12559**  
St. .... Ward)

**2. FULL NAME**

*Arthur Bayless*  
(a) Residence. No. *1930* *Gravies* St. *23* Ward.  
(Usual place of abode)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Nellie Bayless*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *3-13-1885*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>44</i>	<i>9</i>	<i>11</i>	

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work *Labourer*  
(b) General nature of industry, business, or establishment in which employed (or employer) *Odd jobs*  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Wolf Creek*  
(STATE OR COUNTRY) *Ill*

10. NAME OF FATHER *Clark Bayless*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *unknown*  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *unknown*  
(STATE OR COUNTRY)

14. INFORMANT *Nellie Bayless*  
(Address) *1930 Gravies ave*

15. FILED *DEC 26 1929* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 24 19 29*

17. I HEREBY CERTIFY, That I attended deceased from ....., 19 ....., to ....., 19 ....., that I last saw h..... alive on....., and that death occurred, on the date stated above, at *9:55 P.m.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Shock & Injuries (Hemorrhage into Pleural Cavities) due to falling from scaffold*  
(duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY) *accident*  
(duration) ..... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....  
WAS THERE AN AUTOPSY? *yes*

WHAT TEST CONFIRMED DIAGNOSIS  
(Signed) *J. W. Kerner*, M. D.  
*12/25 1929* (Address) *Deputy Coroner*

\*State the DISEASE CAUSING DEATH, or if deaths from VIOLENT CAUSES, state (1) MEANS AND NATURES OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Ziegler Ill.* DATE OF BURIAL *12-25-1929*

20. UNDERTAKER *McLaughlin 1631 Mo. ave.*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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