

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
JAN 8 1939

State File No. 43144
Registrar's No. 300

Registration District No. 213

Primary Registration District No. 3014

1. PLACE OF DEATH:

(a) County Cale
(b) City or town Jefferson City, MO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution St. Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Days
(Specify whether
In this community _____
years, months or days) 700

8. (a) PRINT FULL NAME HENRY BERNARD BAY

8. (b) If veteran, name war None 8. (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 Margaret (Eckhoff) Bay 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased Jan. 13 1873
(Month) (Day) (Year)

8. AGE: Years 66 Months 11 Days 7 If less than one day hr. _____ min. _____

9. Birthplace St. Thomas, MO
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Bernard Bay

13. Birthplace Wrotshale, Germany
(City, town, or county) (State or foreign country)

14. Maiden name Katherine Boegemund

15. Birthplace Wrotshale, Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Frank Bay

(b) Address St. Elizabeth, MO

17. (a) _____ (b) Date thereof 12/20/1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Elizabeth, MO

18. (a) Signature of funeral director Frank Casey

(b) Address Storia, MO

19. (a) 12/23/39 (b) Dr. B. J. ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Miller
(c) City or town St. Elizabeth, MO
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec, day 20
year 1939 hour 5 minute 5 a. M.

21. I hereby certify that I attended the deceased from Dec 18, 1939, to Dec 20, 1939;
that I last saw him alive on Dec 20, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death General Peritonitis Duration 12-18-39

Due to Ruptured Appendicitis 12-15-39

Due to 12/1

Other conditions Cardio Renal disease
(Include pregnancy within 3 months of death)

Major findings: Not operated

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accidents, 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? _____
(Specify type of place) (e) Means of injury _____

23. Signature A. Casman (M. D. or other) MD
Address Jefferson City MO Date signed 12-22-39

MOTHER FATHER

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.