

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9229

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 2712

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 4317 Duke St. 2
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis 15
(If outside city or town limits, write "RURAL")
 (d) Street No. 4317 Duke
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME D. June Bay

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex: Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 30, 1918
(Month) (Day) (Year)

8. AGE: Years 21 Months 6 Days 22 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business _____

12. Name Clarence Bay

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

14. Maiden name Klamert

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

16. (a) Informant's own signature Mrs. Ellen Bay

(b) Address 4317 Duke Street

17. (a) Burial (b) Date thereof 3/25/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Wacker - Welderle

(b) Address 2331 S. Broadway

19. (a) MAR 23 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 21
 year 1940 hour 5 minute 05 p. a. m.

21. I hereby certify that I attended the deceased from 3-16-40
 _____, 19____, to 3-21-40, 19____;
 that I last saw her alive on 3-21-40, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Duration 4 yrs.

Due to _____
 Due to _____

Other conditions G. I. Tuberculosis 2 yrs +
(Include pregnancy within 3 months of death)

Major findings:
 Of operations none
 Of autopsy none
 Underline the cause to which death should be charged statistically.

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 Albert Kaplan (M. D. or other) _____
 Address Mrs. Theatre Bldg. Date signed 3-22-40

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.....

Robert Corbett

Licensed Embalmer No.

2128

P. O. Address.....

St. Louis

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.