

FILED **APR 22 1942**Registration District No. 421Primary Registration District No. 4249Registrar's No. 19

1. PLACE OF DEATH:

(a) County Jefferson
 (b) City or town Crystal City, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1
 (Specify whether
 In this community Twenty-five years
 years, months or days)

3. (a) PRINT

FULL NAME Anna Sophia Bayer

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 Married
 6. (b) Name of husband or wife Sebastian Bayer 6. (c) Age of husband or wife if alive 57 years
 7. Birth date of deceased July 10 1886
 (Month) (Day) (Year)

8. AGE: Years 56 Months 9 Days 4 If less than one day
 hr. _____ min.

9. Birthplace Pennsylvania 1
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Phillip Hess

18. Birthplace Louisville Ky. 1
 (City, town, or county) (State or foreign country)

14. Maiden name Mary Murry

15. Birthplace Weston Mo. 9
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Sebastian Bayer

(b) Address Crystal City, Mo.

17. (a) Burial (b) Date thereof Mar 27-42
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Festes Catholic Cem.

18. (a) Signature of funeral director H. S. Myer

(b) Address Festes Mo.

19. (a) 3-16-42 (b) J. E. Rutledge, M.D.
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jefferson
 (c) City or town Crystal City 050
 (If outside city or town limits, write "RURAL")
 (d) Street No. 304 Jefferson
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? 0 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 14 year 1942 hour 9:00 minute 10 P.M.

21. I hereby certify that I attended the deceased from March 1, 1942, to March 14, 1942
 that I last saw her alive on March 14, 1942
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Heart attack ✓
 Due to High Blood pressure

Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____
 Of autopsy _____

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 J. J. Donnell (M. D. or other) 0
 Address Crystal City, Mo. Date signed 3-16/42

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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

REV. 5-17-39 I 181511

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.

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.....

H. H. Myard
.....
working under my personal supervision.

Registered Apprentice No.

Signed *H. H. Myard*
.....

Licensed Embalmer No. *3010*

P. O. Address *Festus road*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 421

Primary Registration District No. 4249

Registrar's No.

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME Lana S Bayer

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased July 10 (Month) (Day) (Year)

8. AGE: Years 56 Months 9 Days 17 If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry of business _____

12. Name _____

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

14. Maiden name _____ (City, town, or county) (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, that I have seen him/her alive on _____, 19____, and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to Myocardial heart attack

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-11685-1942