

FILED NOV 30 1944
318

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36109

State File No. _____

Registrar's No. 9902

Registration District No. _____

Primary Registration District No. 1002

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

3. (a) PRINT FULL NAME William A. Lay

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Alma Lay 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased April 10 1892
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>52</u>	<u>7</u>	<u>11</u>	hr. _____ min. _____

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

10. Usual occupation printer

11. Industry or business _____

12. Name Fred Lay

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

14. Maiden name Mary A. Rooney

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

16. (a) Informant Alma Lay

(b) Address 5528 Tennessee Avenue
burial (b) Date thereof 11-24-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park Lawn Cemetery

18. (a) Signature of funeral director Southern Funeral Home

(b) Address 6322 So. Grand Blvd.

19. (a) NOV 21 1944 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town city of St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 5528 Tennessee Avenue (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 21st
year 1944 hour 12:15 minute _____ a. M.

21. I hereby certify that I attended the deceased from 11-16-44 to 11-21-44, 1944
that I last saw him alive on 11-20-44, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death: Intestinal Obstruction
Sympho
Due to Intestinal Granulomatosis

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

Major findings: Intestinal Obstruction
Of operations _____
Of autopsy Intestinal Obstruction

Duration 5 days
PHYSICIAN _____
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 B. Ploch (M. D. or other)
Address 2522 Maple, Union, Mo Date signed 11-21-44

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

MOTHER FATHER

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..... *Virgil L. Berryman*.....
Licensed Embalmer No. *4018*.....
P. O. Address..... *St. Louis, Mo.*.....

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, fact should be so stated above.