

#40769

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 10988

FILED APR 27 1945 318

Registration District No. ....

Primary Registration District No. ....

1003

Registrar's No. ....

3464

1. PLACE OF DEATH:

(a) County.....  
(b) City or town..... St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis City Hospital #1. 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... 11 days  
(Specify whether  
In this community.....  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... MISSOURI (b) County..... 000  
(c) City or town..... ST. LOUIS 17 17  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1511 PENNSYLVANIA AV.  
(If rural, give location)  
(e) Citizen of foreign country?..... 0 (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME

William Bayless

3. (b) If veteran,

name war..... NO

3. (c) Social Security

No.....

4. Sex MALE 0

5. Color or race..... WHITE

6. (a) ~~Single~~, widowed, married, divorced..... 0

6. (b) Name of husband or wife.....

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

7. Birth date of deceased

MAY  
(Month)

1 1873  
(Day) (Year)

8. AGE:

Years 71 Months 11 Days 17 If less than one day  
hr. min.

9. Birthplace.....

(City, town, or county) MISSOURI (State or foreign country)

10. Usual occupation.....

NIL

11. Industry or business.....

MOTHER FATHER

12. Name..... John BAYLESS

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

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

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

16. (a) Informant.....

Evelyn Hammett

(b) Address.....

1511 Pennsylvania Av.

17. (a) BURIAL

(Burial, cremation, or removal)

(b) Date thereof..... APRIL 21-45  
(Month) (Day) (Year)

(c) Place: burial or cremation.....

FAIRVIEW Cem. Grubville MO

18. (a) Signature of funeral director.....

E. J. Schurr

(b) Address.....

3125 Lafayette Av.

19. (a) APR 19 1945

(Date received local Registrar)

J. F. Bredek  
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 18th  
year 1945 hour 4:30 minute A. M.

21. I hereby certify that I attended the deceased from 4/7/45  
....., 19....., to 4/18/45....., 19.....;

that I last saw him alive on..... 4/18/45....., 19.....;  
and that death occurred on the date and hour stated above.

Immediate cause of death..... Undetermined Duration

Due to.....

Due to.....

Other conditions..... Hypertension - Corbis - Valvular  
(Include pregnancy within months of death)

Major findings:

Of operations.....  
Of autopsy..... Refused

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..... 0

23. Signature..... W. G. Schurr (M. D. or other)  
Address..... 1515 Lafayette Date signed..... 4/18/45

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

**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 Jose B. Vollmer  
.....

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette Ave

**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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. MassRegistration District No. 318Primary Registration District No. 1003Registrar's No. 2464

## 1. PLACE OF DEATH:

- (a) County St Louis  
 (b) City or town St Louis  
 (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 days3. (a) PRINT FULL NAME Wm Bayless

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex
- M
5. Color or race
- W

6. (a) Single,
- Widow
- , married, divorced

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

7. Birth date of deceased
- May
- (Month)
- 11
- (Day)
- 1945
- (Year)

8. AGE: Years
- 71
- Months
- 11
- Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

- (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(Burial, cremation, or removal)

- (c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

- (b) Address \_\_\_\_\_

19. (a)
- MAY 1 1945
- (Date received local registration) (b)
- J. F. Brudacki
- (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
- April
- year
- 1945
- hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Due to \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

10988