

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 10700

FILED APR 17 1945

Registration District No. 388

Primary Registration District No. 4501

Registrar's No.

1. PLACE OF DEATH:

(a) County Stoddard  
(b) City or town Blountsville  
(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 years, months or days)  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Stoddard  
(c) City or town Blountsville - Mo.  
(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 2 day March  
year 11-40 hour 40 minute 45 M.

21. I hereby certify that I attended the deceased from Mar. 2 - 1945 to Mar. 2 - 1945  
that I last saw alive on March 2 - 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Angina Pectoris  
Due to \_\_\_\_\_  
Duration \_\_\_\_\_

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

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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 J. P. Crandon (M. D. or other) \_\_\_\_\_  
Address Easy, Mo. Date signed 3-5-45

3. (a) PRINT FULL NAME William Francis Bayless

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 Widowed

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

7. Birth date of deceased: Feb. 2 - 1865  
(Month) (Day) (Year)

8. AGE: Years 80 Months 1 Days 17 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Timber man

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

12. Name David Knorr

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

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

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

16. (a) Informant Earl Silversmith

(b) Address Blountsville, Mo.  
Collington, Mo. (c) Date thereof 3-5-45 (Month) (Day) (Year)

(c) Place: burial or cremation Funerary

18. (a) Signature of funeral director Orville Taylor

(b) Address Sebastian, Mo.

19. (a) 3-5-1945 (Date received local registrar) (b) Pearl Churne (Registrar's signature)

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

11.311

RECEIVED

District Health Office No. 2,

District File Number 445-54

Date Filed 4/10/45

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**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... Alfred W. Greer  
Licensed Embalmer No. 1027  
P. O. Address Poplar Bluff, 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.**