

Registration District No. **318** Primary Registration District No. **1007**

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

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:
Missouri Baptist Hospital
(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 (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **St. Francois**
(c) City or town **Desloge**
(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 _____

3. (a) PRINT FULL NAME **Rosie Baylis**
(b) If veteran, name war **Nil**
(c) Social Security No. **Unknown**

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Divorced**
(b) Name of husband or wife **Joseph Baylis** alive **66** years
7. Birth date of deceased **August 25 1894**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
50 11 11 hr. min.

9. Birthplace **Collinsville Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER
12. Name **John Rickmar**
13. Birthplace **Unknown Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown Henson**
15. Birthplace **Unknown Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Halton Ravelle**
(b) Address **Desloge, Mo.**

17. (a) **Burial** (b) Date thereof **8-9-45**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Desloge, Missouri**

18. (a) Signature of funeral director **Albert H. Hoppe**
(b) Address **4700 Washington Blvd.**

19. (a) **AUG 8 1945** (b) **J. Z. Medick**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Aug.** day **6**
year **1945** hour **4:45** minute **A.** M.
21. I hereby certify that I attended the deceased from **Aug-1-45** to **Aug-16-45**
that I last saw her alive on **Aug-5** and that death occurred on the date and hour stated above.

Immediate cause of death: **Chronic Myocarditis with decompensation and Hypertension**
Due to **131**
Other conditions: **Chronic Parenchymatous Nephritis**
Major findings: **None**
Of operations _____
Of autopsy **None**

Duration **3 Mo**
PHYSICIAN **6 mo**
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)
23. Signature **O. O. Smith** (M. D. or other)
Address **526 N. Taylor Ave** Date signed **8/7/45**
St. Louis, Mo.

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.....

W. Wilkins

Licensed Embalmer No. 3575

P. O. Address.....

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.