

No. 300  
-10-47  
5-17-39  
WI 3906

#50242  
FEDERAL SECURITY AGENCY  
National Office of Vital Statistics  
FILED APR 30 1948

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 13849  
Registrar's No. 3754

Registration District No. 318

Primary Registration District No. 1003

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

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-Max C. Starkloff  
(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)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County.....  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5157 Cabanne Ave.  
Memorial (If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Robert Earl Bay  
3. (b) If veteran, name war No  
3. (c) Social Security No. 497-09-8013

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April day 17th  
year 1948 hour 8 minute 30 A. M.  
21. I hereby certify that I attended the deceased from 11/10/47  
April 17th 19 48  
to April 17th 19 48  
that I last saw him alive on April 17th 19 48  
and that death occurred on the date and hour stated above.

4. Sex Male  5. Color or race White  
6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive 20 years  
7. Birth date of deceased. February 20 1911  
(Month) (Day) (Year)

Immediate cause of death  
Spindle cell Sarcoma  
Secondary to old injury of  
left leg Injury of leg occurred  
in 1931 automobile accident  
Due to Gen'l Sarcomatous  
Sarcoma developed from accident  
Other conditions  
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day  
37 1 27 hr. min.

Major findings:  
Of operations Metastatic Sarcoma  
Of autopsy not done  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

9. Birthplace. Salem Missouri  
(City, town, or county) (State or foreign country)  
10. Usual occupation Cook  
11. Industry or business Parkmoor Restaurant

MOTHER FATHER { 12. Name John Bay  
13. Birthplace Dent Co. Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Byerly  
15. Birthplace St. Louis Co. Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant James Bay  
(b) Address 5157 Cabanne Ave.  
17. (a) Burial (b) Date thereof 4-19-48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Bunker, Mo.

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?

18. (a) Signature of funeral director Albert H. Hoppe  
(b) Address 4700 Washington Blvd.  
19. (a) APR 20 1948 (b) J. F. Brewer  
(Date received local registrar) (Registrar's signature)

While at work? (Specify type of place)  
(c) Means of injury 0  
23. Signature W. C. Clark (Mr. or mother)  
Address 1515 Lafayette Date signed 4/17/48

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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.....

*Hewitt M. Brammer*

Licensed Embalmer No. ....

*4200*

P. O. Address.....

*St. Louis*

**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.**