

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

4245

State File No. ....

BIRTH NO. ....		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>500</u>		Registrar's No. <u>0081</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Lemay, Missouri</u>				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Lemay</u>			
c. LENGTH OF STAY (In this place) <u>13 yrs</u>				4870			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>766 Lemay Ferry Road</u>				d. STREET ADDRESS (If rural, give location) <u>766 Lemay Ferry Road</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>William</u>		b. (Middle) <u>Isaac</u>		c. (Last) <u>Bays</u>	
4. DATE OF DEATH		(Month) <u>Jan</u>		(Day) <u>9</u>		(Year) <u>1953</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb 17 1875</u>	9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Grocer</u>		11. BIRTHPLACE (State or foreign country) <u>Iron County, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Robert Bays</u>		13b. MOTHER'S MAIDEN NAME <u>Mattie Mason</u>		14. NAME OF HUSBAND OR WIFE <u>Bertha Bays</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NIL</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Bertha Bays</u> ADDRESS <u>766 Lemay Ferry Road</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> ANTECEDENT CAUSES DUE TO (b) <u>chronic cardiac-vascular disease</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21f. HOW DID INJURY OCCUR?	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>Dec. 1</u> , 19 <u>52</u> , to <u>Jan 9</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>1-9</u> , 19 <u>53</u> , and that death occurred at <u>6:25 P.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Ernest S. Creel</u>		(Degree or title) <u>M.D.</u>		23b. ADDRESS <u>757 Lemay Ferry Rd</u>		23c. DATE SIGNED <u>1-10-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>1-11-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>		24d. LOCATION (City, town, or county) (State) <u>Caledonia, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>1-10-53</u>		REGISTRAR'S SIGNATURE <u>Robert R. Danks</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Albert H. Hoppe</u> ADDRESS <u>4700 Washington</u>			

(Licensed Embalmer's Statement on Reverse Side)

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*John S. Hennrich*

Licensed Embalmer No. *4194*

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.