

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 18 1953

State File No. **15438**
Registrar's No. **3629**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1168 Rowan Avenue.		e. STREET ADDRESS (If rural, give location) 1168 Rowan Avenue	

3. NAME OF DECEASED (Type or Print) a. (First) LUCY b. (Middle) CRAIG c. (Last) BAIR			4. DATE OF DEATH (Month) (Day) (Year) April 6, 1953		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 4, 1900	9. AGE (In years last birthday) 53	10. UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier		10b. KIND OF BUSINESS OR INDUSTRY Retired 12 years		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME I. Newton Craig		13b. MOTHER'S MAIDEN NAME Anna Morrison		14. NAME OF HUSBAND OR WIFE Thales W. Bair	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 492-01-6298		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Thales W. Bair, 1168 Rowan Avenue.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION Multiple Sclerosis			INTERVAL BETWEEN ONSET AND DEATH 16 years	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		DUPLICATE TO (b)				
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		DUPLICATE 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)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 345X		

22. I hereby certify that I attended the deceased from **March 28, 1953**, to **April 6, 1953**, that I last saw the deceased alive on **March 28, 1953**, and that death occurred at **1:30 A. M.**, from the causes and on the date stated above.

23a. SIGNATURE Frank Turner (Degree or title) M.D.		23b. ADDRESS 1251 Blackstone		23c. DATE SIGNED April 6-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE April 9, 1953		24c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery	
				24d. LOCATION (City, town, or county) (State) St. Louis Co. Missouri	

DATE REC'D BY LOCAL REG. APR 6 1953		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Shepard Funeral Home 1167 Hamilton Ave	
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Robert M. Murray

Licensed Embalmer No. 3749

P. O. Address St. Louis, Mo.

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.