

FILED NOV 29 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39279

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 2657

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) Normandy		c. CITY (If outside corporate limits, write RURAL and give township) Woodson Terrace	
c. LENGTH OF STAY (in this place) D. O. A.		d. STREET ADDRESS (If rural, give location) 10124 Natural Bridge Rd.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Normandy Osteopathic Hospo			

3. NAME OF DECEASED (Type or Print) a. (First) Patrick b. (Middle) Joseph c. (Last) Bayless			4. DATE OF DEATH (Month) (Day) (Year) Nov. 12, 1955.		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 5-6-53	9. AGE (In years last birthday) 2	IF UNDER 1 YEAR Months 6 Days 6
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and State or Foreign Country) Normandy, Mo.		12. CITIZEN OF WHAT COUNTRY? U. S.

13a. FATHER'S NAME Robert W. Bayless		13b. MOTHER'S MAIDEN NAME Ruth Heffernan		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Robert W Bayless, St. Louis 21, M	

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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Arrest		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Enlarged Thyroid		
	DUE TO (c) Acute Upper Respiratory Infection		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		4 hrs	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 273x	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) m.	21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/12, 1955, to 11/12, 1955, that I last saw the deceased alive on 11/12, 1955, and that death occurred at 9:45 a. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W. A. Sardus M.D.	23b. ADDRESS 917 Airport Rd. Ferguson	23c. DATE SIGNED 11/13/55
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11-14-55.	24c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery
		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.

DATE REC'D BY LOCAL REG. 11-14-55	REGISTRAR'S SIGNATURE Herbert R. Dombard	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS WHITE CHAPEL, FERGUSON, MO.
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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 Elena Province

Licensed Embalmer No. 3403

P. O. Address Jennings 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.