

FILED JAN 7 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 1879

Registration District No. 178 Primary Registration District No. 5666 Registrar's No. 1

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
a. COUNTY LEWIS COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN LA GRANGE		a. STATE MO		b. COUNTY LEWIS		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION HOME		Length of stay in 1b		c. CITY OR TOWN LA GRANGE		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH				
First SARAH		Middle		Last BAYLES		Month Day Year 1 4 57		
5. SEX FEMALE		6. COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 27 1867		
9. AGE (In years last birthday) 89		10. KIND OF BUSINESS OR INDUSTRY HOUSE WIFE		11. BIRTHPLACE (City and state or country) LEWIS COUNTY		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME FRANK WILLIAMS				14. MOTHER'S MAIDEN NAME ELLA ?				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Edith MAJORS LAGRANGE, MO. Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC MYOCARDITIS Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 4222 DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HEMIPLÉGIA DUE TO CEREBRAL HEMORRHAGE							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						
Hour Month, Day, Year		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE		
21. I attended the deceased from JAN 1955 to JAN 1957 and last saw her alive on DEC 27 1956 Death occurred at 2:30 PM m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE W F Colley MD (Degree or title)				22b. ADDRESS La Grange MO		22c. DATE SIGNED 1/5/57		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE JAN 4 1957		23c. NAME OF CEMETERY OR CREMATORY RIVER VIEW CEMETERY		23d. LOCATION (City, town, or county) LA GRANGE MO. (State)		
24. FUNERAL DIRECTOR Geo E Roberts			ADDRESS Hannibal MO		25. DATE RECD. BY LOCAL REG. 1-5-57		26. REGISTRAR'S SIGNATURE P. W. Jennings MD	

(Licensed Embalmer's Statement on Reverse Side)

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

000
56

100 30 10157

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-
-by me, or by Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Geo E Roberts*

Licensed Embalmer No. *21*

P. O. Address *Hannover*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.