

FILED AUG 26 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29198**
Registrar's No. **7583**

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

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE Mo. b. COUNTY Franklin	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis	c. LENGTH OF STAY (in this place)	c. CITY OR TOWN Robertsville	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION 26 1832A Mullanthy		e. STREET ADDRESS (If rural, give location) 31	

3. NAME OF DECEASED (Type or Print) a. (First) Chris b. (Middle) C. c. (Last) Bay		4. DATE OF DEATH (Month) (Day) (Year) Aug 13 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Dec 31-1869
9. AGE (In years last birthday) 87	10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) farmer	11. BIRTHPLACE (City and State or Foreign Country) not known	12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME not known	13b. MOTHER'S MAIDEN NAME not known	14. NAME OF HUSBAND OR WIFE Rosa Laura Bay
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Chris Gardner (grandson) Bloomington

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.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) cranial hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 3 wks.
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerosis DUE TO (c) hypertensive disease.		
	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) 331X
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?

22. I hereby certify that I attended the deceased from **Dec 1949**, to **Aug 13, 1957**, that I last saw the deceased alive on **Aug 13, 1957**, and that death occurred at **4 A. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) [Signature]	23b. ADDRESS Pacific Mo	23c. DATE SIGNED 8/13/57
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Aug 13	24c. NAME OF CEMETERY OR CREMATOR Mount Olive
		24d. LOCATION (City, town, or county) (State) Robertsville Mo.

DATE REC'D BY LOCAL REG. AUG 14 57	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Mrs. John L. Thelen, Pacific Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

1861 6 100

STATEMENT BY LICENSED EMBALMER

Handwritten notes:
Name of Deceased
Date of Death

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
Signature of Student Embalmer

Signed *Ralph Ottmann*

Licensed Embalmer No. *4800*

P. O. Address *Union, N.J.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.