

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2621

STATE FILE NUMBER

FILED JAN 30 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

841

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Clay	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR ST. LOUIS, MISSOURI		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Flora
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) R. R. # 2
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First LESTER Middle L. Last BAY			4. DATE OF DEATH Month JANUARY Day 22 Year 1958		
--	--	--	---	--	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12, 1907	9. AGE (In years last birthday) 50 IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
-----------------------	----------------------------------	---	--	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Vaccum Cleaner	11. BIRTHPLACE (City and state or country) Clay County, Ill.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
--	--	--	--	---	--

13a. FATHER'S NAME William Bay		13b. MOTHER'S MAIDEN NAME Ollie Babcock		14. NAME OF HUSBAND OR WIFE Lucille Bay	
--	--	---	--	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No.		16. SOCIAL SECURITY NO. Nil.	17. INFORMANT Address Lucille Bay Jr. R. R. 2 Flora, Ill.		
--	--	--	--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GANGRENE OF SMALL BOWEL			INTERVAL BETWEEN ONSET AND DEATH 36 HOURS
DUE TO (b) COMPLETE VOLVULUS OF SMALL BOWEL, IDIOPATHIC			
DUE TO (c) ACUTE APPENDICITIS			9 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 7 DAYS			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 Hour Month, Day, Year a.m. p.m.			20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
---	--	--	---	--	--

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. 19, 1958 to JAN. 22, 1958 and last saw ^{her} him alive on JAN. 22, 1958 Death occurred at 4:30 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
---	--	--	--	--	--

22a. SIGNATURE <i>C. Venellia, M. P.</i> (Degree or title) M. D.		22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 1/22/58	
---	--	--	--	------------------------------------	--

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 1-22-58	23c. NAME OF CEMETERY OR CREMATORY Clay City Cemetery		23d. LOCATION (City, town, or country) (State) Clay City, Ill.
---	--	-----------------------------	---	--	--

24. FUNERAL DIRECTOR Albert H. Hoppe		ADDRESS 4700 Washington, Blvd.	25. DATE RECD. BY LOCAL REG. JAN 23 '58	26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i> MS	
--	--	--	---	--	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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
Signature of Student Embalmer

Signed *Edmond P. Penwell*

Licensed Embalmer No. *4283*

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