

Health,
Welfare
Public
Service

FILED FEB 6 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3207
STATE FILE NUMBER
904

Registration District No. _____

318

Primary Registration District No. _____

1003

Registrar's No. _____

300
1-57

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, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 4271 St. Louis Ave	

3. NAME OF DECEASED (Type or print) First Middle Last ETHEL LOUISE LAY			4. DATE OF DEATH Month Day Year JANUARY 22, 1958		
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5. SEX Female	6. COLOR OR RACE Negro	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH July 1, 1927	9. AGE (In years last birthday) 30	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Orlando Florida	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Douglas Brannon	13b. MOTHER'S MAIDEN NAME Mattie (Unk.)	14. NAME OF HUSBAND OR WIFE Walter Lay
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None	16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mr. Walter Lay 4271 St. Louis Ave.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLI, MULTIPLE		INTERVAL BETWEEN ONSET AND DEATH 4 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) ACQUIRED HEMOLYTIC ANEMIA	
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	

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.)
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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
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21. I attended the deceased from MARCH 13, 1947 to JAN. 22, 1958 and last saw her alive on JAN. 22, 1958 Death occurred at 8:45 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Dress or title) C. D. Vermillion, M. D.	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 1/22/58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1-28-58	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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24. FUNERAL DIRECTOR ADDRESS G. Wade Granberry 4202 Finney Ave.	25. DATE RECD. BY LOCAL REG. JAN 24 '58	26. REGISTRAR'S SIGNATURE J. Carl Smith
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with or without.

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 *Guyton Swan*

Licensed Embalmer No. 4580
P. O. Address 5224 Palm

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.