

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007919
STATE FILE NUMBER

FILED FEB 24 1959

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 486

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 OR TOWN Clayton <i>(Outside corporate limits give district and city or town)</i>		c. CITY OR TOWN Webster Groves <i>(If outside, give location)</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hospital		Length of stay in lb 16 days	
3. NAME OF DECEASED (Type or print) First Everett Middle B. Last DeLay Jr.		4. DATE OF DEATH Month Feb. Day 18th Year 1959	
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. 2nd 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Newspaper	
13a. FATHER'S NAME Everett B. DeLay		13b. MOTHER'S MAIDEN NAME Anna Proetz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give branch or dates of service) No		17. INFORMANT Martha DeLay Address Above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Hypostatic Pneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Carcinoma of Bladder, Transitional cell. DUE TO (c) Uremia due to renal shutdown.			INTERVAL BETWEEN ONSET AND DEATH abt. 2 days abt. 2 yr.
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) - 5 days - 1810	
20c. TIME OF INJURY Hour 1:55 Month, Day, Year 2-19-59 a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <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 11-14-58 to 2-19-59 and last saw her/him alive on 2-18-59 Death occurred at 1:55 a. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) A. K. Dusek MD		22b. ADDRESS 7500 Danawhine, St. Louis 19	
22c. DATE SIGNED 2-19-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-21-59	23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cem.	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
24. FUNERAL DIRECTOR JAY B. SMITH, Maplewood, Mo.		25. DATE RECD. BY LOCAL REG. 2-19-59	26. REGISTRAR'S SIGNATURE John E. Murphy M.D.

Health, Welfare, Public Service

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-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *A. J. Burgess*

Licensed Embalmer No. *4029*

P. O. Address *Maplewood*

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.