

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 45 2 2 2

FILED VS JAN 11 1960

211690

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		c. CITY OR TOWN <b>Clayton</b>	
Length of stay in 1b <b>1yr.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Masonic Home Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>316 N. Brentwood Blvd.</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Rose</b> Middle <b>Bayer</b> Last <b>Bayer</b>	4. DATE OF DEATH Month <b>Dec.</b> Day <b>14</b> Year <b>1959</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-14-1877</b>	9. AGE (last birthday) <b>82</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Washington, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>August Iserman</b>	13b. MOTHER'S MAIDEN NAME <b>Sophia Ehlers</b>	14. NAME OF HUSBAND OR WIFE <b>Thomas E. Bayer</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Masonic Hospital Records</b>	Address <b>5351 Delmar</b>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b>		<b>3DAYS</b>
DUE TO (b) <b>CONVULSIONS</b>		<b>3DAYS</b>
DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE 420.0</b>		<b>UNKNOWN</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year
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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
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21. I attended the deceased from **12-16-58** to **12-14-59** and last saw her/him alive on **12-13-59**  
Death occurred at **6:10AM** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Harold E. Walters</b> (Degree or title)	22b. ADDRESS <b>3720 Washington Ave.</b>	22c. DATE SIGNED <b>12-14-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>12-14-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>
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24. FUNERAL DIRECTOR <b>Louis H. Bopp,</b> ADDRESS <b>Kirkwood, Missouri</b>	25. DATE RECD. BY LOCAL REG. <b>DEC 17 1959</b>	26. REGISTRAR'S SIGNATURE <b>Loal Smith, M.D.</b> <i>ms</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

11/17/41

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded ~~on the~~ reverse side of this certificate was embalmed by not  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Francis Myland  
Licensed Embalmer No. 4572  
P. O. Address Highway

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.