RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS JAN 15 1960

-60-003137

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 23

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: CONGRESS HOTEL
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 275 No. Union Blvd
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: MAUDE Middle: H. Last: BAY.

4. DATE OF DEATH: Month: Jan. Day: 1, Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 10/19/1881

9. AGE (last birthday): 78

IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HR: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home

10b. KIND OF BUSINESS OR INDUSTRY: housewife

11. BIRTHPLACE (City and state or country): Bridgeport Conn.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Louis H. Hubbell

13b. MOTHER'S MAIDEN NAME: Ida Meeker

14. NAME OF HUSBAND OR WIFE: Mansfield C. Bay

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): none

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mr. Mansfield C. Bay Address: St. Louis Mo. 275 N. Union Bv

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 10 min.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic Heart disease — 10 years

DUE TO (c): 420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Diabetes mellitus

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 May 20 1949 to Jan 1 1960 and last saw her/him alive on Nov 23 1959

Death occurred at 10 30 pm. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Samuel B Grant M.D. (Degree or title)

22b. ADDRESS: 114 N. Taylor Ave

22c. DATE SIGNED: 1-4-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE: Jan 4, 1960

23c. NAME OF CEMETERY OR CREMATORY: Oak Grove Crematory

23d. LOCATION (City, town, or county) (State): St. Louis County Missouri.

24. FUNERAL DIRECTOR: C.R. Lupton and Sons ADDRESS: 7233 Delmar Blv'd.

25. DATE RECD. BY LOCAL REG.: JAN 4 1960

26. REGISTRAR'S SIGNATURE: Hearl Smith. M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Clarence H. Mu

Signature of Student Embalmer

Licensed Embalmer No. 4011

P. O. Address St. Lou

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to cor 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.