

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-015076

FILED VS APR 25 1960

STATE FILE NUMBER

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 65

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Howell</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> COUNTY <b>Howell</b> |  |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>West Plains</b>  |  | Length of stay in lb<br><b>17 years</b>   |  | c. CITY OR TOWN <b>West Plains</b>   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION   |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location)<br><b>1109 Webster</b>   |  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>Lewis Emery Bay</b>   |  |   |  | 4. DATE OF DEATH Month Day Year<br><b>April 13, 1960</b>   |  |  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>       | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>4-9-1876</b>  | 9. AGE (last birthday)<br><b>85</b>                                      | IF UNDER 1 YEAR<br>Months Days   | IF UNDER 24 HR<br>Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Farmer</b>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farming</b>                                  |  | 11. BIRTHPLACE (City and state or country)<br><b>Missouri</b>            |  | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>                                  |
| 13a. FATHER'S NAME<br><b>William Bay</b>   |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Molly</b>  |  |  | 14. NAME OF HUSBAND OR WIFE<br><b>Viola Jane Bay</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No None</b>  |  |   | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  | 17. INFORMANT Address<br><b>Mrs. Jack Shelton, West Plains, Mo.</b>      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b>   |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>MINUTES</b>   |  |
| DUE TO (b) <b>CEREBRAL ARTERIOSCLEROSIS</b>  |  |   |  |  |  | <b>YEARS</b>   |  |
| DUE TO (c)   |  |   |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the immediate cause (List in Part I (a))<br><b>ARTERIO SCLEROSIS PREVIOUS CVA HYPERTENSION SENILITY</b>   |  |   |  |  |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |
| 19. WAS AUTOPSY PERFORMED<br>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.)   |  |  |  |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. p.m.  |  |   |  |  |  |  |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <b>6-3-57 to 4-13-60</b> and last saw him alive on <b>12-14-59</b><br>Death occurred at <b>About 11 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |  |  |  |  |
| 22a. SIGNATURE (Degree or title)<br><b>Jack H. Wilcox, M.D. West Plains, Mo.</b>   |  |   |  | 22b. ADDRESS   |  | 22c. DATE SIGNED<br><b>4-15-60</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>4-15-1960</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>                       |  | 23d. LOCATION (City, town, or county) (State)<br><b>West Plains, Mo.</b> |  |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Leiland Carter West Plains, Mo.</b>   |  |   |  | 25. DATE RECD. BY LOCAL REG.<br><b>4-18-60</b>   |  | 26. REGISTRAR'S SIGNATURE<br><b>Beatrice Cook</b>  |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

APR 27 196

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

Signed Richard Carter

Licensed Embalmer No. 4576  
P. O. Address West O.

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.