

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-047844

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3641 STATE FILE NUMBER

**FILED JAN 19 1962**

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>Saint Louis</b>	a. STATE <b>Missouri</b> b. COUNTY		admission)
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Normandy</b>	Length of stay in 1b <b>39 days</b>	c. CITY OR TOWN <b>Saint Louis</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Normandy Osteopathic Hosp.</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <b>4975 Arsenal</b>	(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <b>William</b>	Middle <b>R.</b>	Last <b>Bay</b>	4. DATE OF DEATH	Month <b>Dec.</b>	Day <b>19,</b>	Year <b>1961</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6-6-1890</b>	9. AGE (last birthday) <b>71</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Elec. Maintenance</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>City of St. Louis</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U S A</b>
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13a. FATHER'S NAME <b>William Gottlieb Bay</b>	13b. MOTHER'S MAIDEN NAME <b>Wilhelmina Doering</b>	14. NAME OF HUSBAND OR WIFE <b>Amanda Evers Bay</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.	17. INFORMANT <b>Mrs. Amanda Bay 4975 Arsenal Street</b>	Address
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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>GENERALIZED CARCINOMATOSIS</b>	<b>12 MOS.</b>
DUE TO (b)	<b>PRIMARY CARCINOMA OF PROSTATE</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Supra-pubic cystostomy; bilateral ureteral transplant, repair of wound evisceration.</b>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 1-5-61 to 12-19-61 and last saw her/him alive on 12-19-61  
Death occurred at 4:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Samuel Gibson</i>	(Degree or title)	22b. ADDRESS <b>1520 Natural Bridge</b>	22c. DATE SIGNED <b>12-20-61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Dec. 22, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Our Redeemer Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>
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24. FUNERAL DIRECTOR <b>Beiderwieden F.H. Inc. 1936 St. Louis Ave.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>12-22-61</b>	26. REGISTRAR'S SIGNATURE <i>June B. Murphy M.D.</i>
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DATE AMENDED

INSTEAD OF

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

ORIGINAL COPY

**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 \_\_\_\_\_

Licensed Embalmer No. 452  
P. O. Address \_\_\_\_\_

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.