

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014669

STATE FILE NUMBER

2 3929

FILED MAY 8 1959 Registration District No. Primary Registration District No. Registrar's

1. PLACE OF DEATH a. COUNTY <u>St. Louis City</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <u>St. Louis</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kirkwood</u> 4673 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in 1b HOSPITAL OR INSTITUTION <u>St. Lukes</u>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> <u>#1 Sunset Lane</u>	

3. NAME OF DECEASED (Type or print) First <u>Leo</u> Middle <u>JNO</u> Last <u>Bayer</u>			4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/27/86</u>	9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months _____ Days _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRESIDENT</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>BAYER Co.</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13. FATHER'S NAME <u>FRANK X BAYER</u>	14. MOTHER'S MAIDEN NAME <u>ANNA WIND</u>
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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) <u>NO</u>	16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT Address <u>BERTHA BAYER #1 SUNSET LANE</u>
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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: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease with Failure - Pulmonary Congestion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 mos</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>420.0</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.) <u>420.0</u>
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20c. TIME OF INJURY Hour _____ 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
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21. I attended the deceased from <u>Jan 1959</u> to <u>4/18/59</u> and last saw her <u>alive</u> on <u>4/17/59</u> Death occurred at <u>12:30 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>Leo J. Keenan M.D.</u>	22b. ADDRESS <u>St. Louis, Mo</u>	22c. DATE SIGNED <u>4/18/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>4/22/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SUNSET BURIAL PARK</u>	23d. LOCATION (City, town, or county) (State) <u>AFTON, Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>J L ZIEGENHEIN & SONS 7027 GRAVOIS</u>	25. DATE RECD. BY LOCAL REG. <u>APR 21 '59</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith, M.D.</u>
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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was
by me, or by Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Donald E. Benz*.....
Licensed Embalmer No. *48*.....

P. O. Address *7027*.....

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