

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 173 -61-002917  
 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Length of stay in 1b <u>20 yrs.</u>	c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>200a Geyer</u>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>H.</u> Last <u>BYASSEE</u>			4. DATE OF DEATH Month <u>JANUARY</u> Day <u>5</u> Year <u>1961</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>12/3/1895</u>	9. AGE (last birthday) <u>65</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Order Filler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rice Stix Dry Goods</u>		11. BIRTHPLACE (City and state or country) <u>Bardwell, Ky. U.S.</u>	
13a. FATHER'S NAME <u>Frank Byassee</u>		13b. MOTHER'S MAIDEN NAME <u>Sally Sams</u>		14. NAME OF HUSBAND OR WIFE <u>May Idelle Byassee</u>	
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>Unknown</u>		17. INFORMANT <u>Robert Byassee, 529 Holiday Ave.</u>	
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>CEREBRAL VASCULAR ACCIDENT</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u>
DUE TO (b) <u>POST-OPERATIVE EMBOLIZATION FROM THROMBOPHLEBITIS OF LOWER EXTREMITIES</u>					<u>2-3 WEEKS</u>
DUE TO (c) <u>CHRONIC VARTICOSE VEINS OF LOWER EXTREMITIES</u>					<u>20-30 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>460+</u>					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
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.)			
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year					
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
21. I attended the deceased from <u>APRIL 27, 1956</u> , to <u>JAN. 5, 1961</u> and last saw her alive on <u>JAN. 5, 1961</u> Death occurred at <u>7:45 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>C. E. Vermillion, M.D.</u>			22b. ADDRESS <u>BARNES HOSPITAL</u>		22c. DATE SIGNED <u>1/5/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1-7-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Zoar Cemetery</u>		23d. LOCATION (City, town, or county) <u>Lowes, Ky.</u>	
24. FUNERAL DIRECTOR <u>Albert H. Hoppe, Inc., 4700 Washington Blvd.</u>			25. DATE RECD. BY LOCAL REG. <u>JAN 6 1961</u>	26. REGISTRAR'S SIGNATURE <u>Loal Smith M.D.</u>	

DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ

STATE OF MISSOURI  
DEPARTMENT OF HEALTH

STATE OF MISSOURI  
DEPARTMENT OF HEALTH  
BUREAU OF HEALTH

STATE OF MISSOURI  
DEPARTMENT OF HEALTH  
BUREAU OF HEALTH  
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 J. W. Dumbly

Licensed Embalmer No. 3653

P. O. Address St Louis 8 Mo

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.