

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-037289

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 370

FILED SEP 19 1963

DO NOT WRITE ON THIS STUD

AMENDED

VS 300  
Rev. 4/59

1 0941

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>St. Francois</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. <b>Missouri</b> b. COUNTY <b>St. Francois</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Bonne Terre</b>		Length of stay in 1b <b>14 Hrs.</b>	c. CITY OR TOWN <b>Flat River</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>Bonne Terre Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>500 Lewis St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>LILLIE MAY BAY</b>			4. DATE OF DEATH Month Day Year <b>Sept. 10, 1963</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8/16/1887</b>
9. AGE (last birthday) <b>76</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>24</b>	IF UNDER 24 HR Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>St. Francois Co. Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>William Redfearn</b>	
13b. MOTHER'S MAIDEN NAME <b>Cassie Marlow</b>		14. NAME OF HUSBAND OR WIFE <b>Clarence E. Bay</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <b>no</b>		16. SOCIAL SECURITY NO. <b>1</b>	
17. INFORMANT <b>J. E. Bay</b>		Address <b>Flat River, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day.</b>
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)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 <b>Sept 7, 1963</b> to <b>Sept 10, 1963</b> and last saw her alive on <b>Sept 10, 1963</b> Death occurred at <b>6:30 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>J. I. Foster M.D.</b> (Degree or title)		22b. ADDRESS <b>Desloge, Missouri</b>	22c. DATE SIGNED <b>9/11/63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9/12/1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Francois Memo.</b>	23d. LOCATION (City, town, or county) (State) <b>St. Francois Co. Mo.</b>
24. FUNERAL DIRECTOR <b>Murphy L. Sparks</b> Flat River, Mo.		25. DATE RECD. BY LOCAL REG. <b>Sept. 11, 1963</b>	26. REGISTRAR'S SIGNATURE <b>Esther Rudloff</b>

020170-000

signature . . . . .

**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 Murphy L Sparks

Licensed Embalmer No. 4236

P. O. Address Hot Springs, 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.

020170

signature . . . . .

signature . . . . .