

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

3175

1. PLACE OF DEATH

County St. Louis
Township St. Louis
City St. Louis

Registration District No. 797
Primary Registration District No. 1005
(No. 4174 Shaw Ave)

File No. _____
Registered No. 389
St. _____ Ward _____

2. FULL NAME

Susan Mae Bailey
(a) Residence. No. 4174 Shaw Ave St. 17 Ward.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widowed</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>late William Mc Bailey</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Dec 10, 1837</u>				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>93</u>	<u>0</u>	<u>0</u>	<u>29</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Joliet Illinois
(STATE OR COUNTRY) Illinois

PARENTS	10. NAME OF FATHER <u>Moses Waugh</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown</u>
	12. MAIDEN NAME OF MOTHER <u>Margaret Mc Bailey</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown</u>

14. INFORMANT Miss Margaret Mc Bailey
(Address) 4174 Shaw Ave

15. FILED 11/19/31 W. C. Walker
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1 - 8 1931

17. I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1924, to Jan. 8, 1931, that I last saw him alive on Jan. 8, 1931, and that death occurred, on the date stated above, at 7:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Interstitial Nephritis
131
93c (duration) 8 yrs. mos. ds.

CONTRIBUTORY Chronic Myocarditis
(SECONDARY) (duration) 8 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Physical examination
(Signed) A. P. Shueppel M. D.
11/13/31, 19 (Address) 1020 Mrs. Bery - St. Louis, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL <u>Calvary Cemetery</u>	DATE OF BURIAL <u>1-12 1931</u>
20. UNDERTAKER <u>Tracy Chausse Co. Sinking Highway</u>	ADDRESS <u>4238</u>

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

