

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

Do not use this space.

8374

1. PLACE OF DEATH

County..... Registration District No. 701
 Township..... Primary Registration District No. 1003
 City St. Louis (No. ISOLATION HOSPITAL) St. _____ Ward _____

File No. _____
 Registered No. 2921 St. _____ Ward _____

2. FULL NAME

Bud Bailey
 (a) Residence. No. R.P. 127 Creve Coeur St. 13 Ward. St. Louis Co. Mo
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>July 3, 1904</u>		
7. AGE	YEARS	MONTHS
	<u>26</u>	<u>7</u>
		DAYS
		<u>24</u>
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work <u>Cook 231</u>		
(b) General nature of industry, business, or establishment in which employed (or employer)		
(c) Name of employer		

9. BIRTHPLACE (CITY OR TOWN)..... Texas 2
 (STATE OR COUNTRY)

10. NAME OF FATHER Wm. A. Bailey

11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... Ky.
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Della Gresham

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... Ark.
 (STATE OR COUNTRY)

14. INFORMANT..... Lorraine Krohn
 (Address) ISOLATION HOSPITAL

15. FILED..... 1931
 REGISTRAR W. C. Starnes

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-26 1931

17. I HEREBY CERTIFY, That I attended deceased from 2-23, 1931, to 2-26, 1931, and that I last saw him alive on 2-26, 1931, and that death occurred, on the date stated above, at 8:10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Crysipelas, facial
 (duration) yrs. mos. 4 ds.
 CONTRIBUTORY Pneumonia -
 (SECONDARY) (duration) yrs. mos. ? ds.

18. WHERE WAS DISEASE CONTRACTED..... D
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH, no DATE OF.....
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) P. F. Tompase M. D.
 (Address) ISOLATION HOSPITAL

*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..... Peterfeld
 DATE OF BURIAL..... 3-6-1931

20. UNDERTAKER..... John Schumaker
 ADDRESS..... 5800

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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