

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27633

REG'D SEP 14 1939
Registration District No. 1008

Primary Registration District No. _____

Registrar's No. 7133

1. PLACE OF DEATH: **1008**
(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer Phillips /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Since 7/12/39
(Specify whether _____)

In this community _____
years, months or days)

3. (a) PRINT FULL NAME Alice Bailey 400
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race C 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec. 11, 1880
(Month) (Day) (Year)

8. AGE: Years 58 Months 8 Days 5 If less than one day _____ hr. _____ min.

9. Birthplace Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation nil

11. Industry or business _____

MOTHER FATHER { 12. Name Henry Smith

13. Birthplace Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Sara Wilson

15. Birthplace Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Allie Johnson

(b) Address 1621 Wash St

17. (a) Burial (b) Date thereof 8-19-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Demetrius

(b) Address 2631 Wash St

19. (a) AUG 17 1939 (b) _____
(Date received local registrar) (Specify type of certificate)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri / (b) County _____
(c) City or town St. Louis 125
(If outside city or town limits, write "RURAL")
(d) Street No. 1621 Wash (rear)
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 16
year 1939 hour 2 minute 20 a. m.

21. I hereby certify that I attended the deceased from July 12, 1939
_____, 19____, to Aug. 16, 1939, 19____;
that I last saw her alive on Aug. 16, 1939, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration
Hypertensive heart disease 6-8 yrs.
Arteriosclerotic nephritis 2-3 yrs.

Due to _____

Due to _____

Other conditions Hydrothorax abt. 1 mo.
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

28. Signature H. J. Lyman (M.D. or other)

Address 2601 DuBois Date signed 8/16/39

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033015 02 11 01 1 01

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed

Arthur R. Heilliard

Licensed Embalmer No.

3389

P. O. Address

3028 Dickson S

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 this body is not embalmed, above space should be left blank.