

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Registration District No. **784** Primary Registration District No. **200** Registrar's No. **1631**

**1. PLACE OF DEATH:**  
 (a) County ST. LOUIS  
 (b) City or town KOCH  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: ROBERT KOCH HOSPITAL  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 3 yrs, 2 months  
 (Specify whether  
 In this community 45 years  
 years, months or days)

**8. (a) PRINT FULL NAME:** FRANCIS (FRANK) DAILEY

**3. (b) If veteran,** name war \_\_\_\_\_ **3. (c) Social Security** No. \_\_\_\_\_

**4. Sex:** M **5. Color or** W **6. (e) Single, widowed, married,** Div  
 race W divorced \_\_\_\_\_

**6. (b) Name of husband or wife** \_\_\_\_\_ **6. (c) Age of husband or wife if** \_\_\_\_\_  
 alive \_\_\_\_\_ years

**7. Birth date of deceased:** OCTOBER 24, 1867  
 (Month) (Day) (Year)

**8. AGE:** Years 72 Months 10 Days 1 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min

**9. Birthplace:** PEORIA ILLINOIS  
 (City, town, or county) (State or foreign country)

**10. Usual occupation:** HOTEL PORTER

**11. Industry or business:** HOTEL

**MOTHER FATHER**  
**12. Name:** PETER DAILEY  
**13. Birthplace:** PEORIA ILLINOIS  
 (City, town, or county) (State or foreign country)  
**14. Maiden name:** ANNA LAUGAKIN  
**15. Birthplace:** IRELAND  
 (City, town, or county) (State or foreign country)

**16. (a) Informant:** Koch Hosp  
 (b) Address: Koch 200  
**17. (a) Burial, cremation, or removal:** Calvary (b) Date thereof: 8/28/40  
 (Month) (Day) (Year)  
 (c) Place: burial or cremation \_\_\_\_\_

**18. (a) Signature of funeral director:** Herbert F. Schwartz  
 (b) Address: 1524 Lafayette St. St. Louis  
**19. (a) AUG 27 1940** (b) Herbert F. Schwartz  
 (Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State MISSOURI (b) County ST. LOUIS  
 (c) City or town ST. LOUIS  
 (If outside city or town limit, write "RURAL")  
 Street No. 8207 CHESTNUT  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month AUGUST day 25 1940  
 year 1940 hour 5 minute 55 P.M.

**21. I hereby certify that I attended the deceased from** JUNE 26, 1937 to AUGUST 25, 1940  
 that I last saw him alive on AUGUST 25, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death CHRONIC PULMONARY TUBERCULOSIS

Due to 236  
 Due to \_\_\_\_\_

Other conditions SENILITY  
 (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
 Of autopsy PULMONARY TUBERCULOSIS

**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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
**23. Signature:** Herbert F. Schwartz (M. D. or other) \_\_\_\_\_  
 Address: Koch Hospital, Koch Date signed 8-27-40

Duration \_\_\_\_\_  
INDEF  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

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