

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

30061

Registration District No. **791**Primary Registration District No. **1003**Registrar's No. **7228**

1. PLACE OF DEATH:

(a) County _____
 (b) City or town ST. LOUIS, MISSOURI
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
BARNES HOSPITAL
 (If not in hospital or institution, write street number or location) 1
 (d) Length of stay: In hospital or institution 5 days
 (Specify whether _____)
 In this community 25 yrs
 years, months or days)

8. (a) PRINT FULL NAME WALTER ERWIN BAILEY8. (b) If veteran SS. 495-12 5902 name war NONE 8. (c) Social Security No. NONE

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced MARRIED
 6. (b) Name of husband or wife LILLIAN BAILEY 6. (c) Age of husband or wife if alive 52 years
 7. Birth date of deceased 1 4 13 1853
 (Month) (Day) (Year)

8. AGE: Years 57 Months 4 Days 18 If less than one day
 hr. _____ min. _____

9. Birthplace NEW YORK CITY NEW YORK
(City, town, or county) (State or foreign country)10. Usual occupation FOOD BROKER11. Industry or business KILEY BRO CO12. Name S. BAILEY18. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)14. Maiden name UNKNOWN
15. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)16. (a) Informant's own signature LILLIAN BAILEY(b) Address 3551 VICTOR ST17. (a) BURIAL (b) Date thereof 9 13 40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation SUNSET BURIAL PARK18. (a) Signature of funeral director KRIEGER HAUER(b) Address 4228 So. KINGMAN HWY19. (a) SEP 2 1940 (b) _____
(Date of local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County _____
 (c) City or town ST. LOUIS 17
 (If outside city or town limits, write "RURAL") 0
 (d) Street No. 3551 VICTOR ST
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUGUST day 31
year 1940 hour 7 minute 25 P.M.21. I hereby certify that I attended the deceased from 8-27-40
_____, 19____, to 8-31-40, 19____;
that I last saw him 1m alive on 8-31-40
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Uremia
liver failure
 Due to Portal cirrhosis

Due to _____

Other conditions Syphilis
(Include pregnancy within 3 months of death) 34Major 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 _____23. Signature W. R. Bierman, M.D. (M.D. or other)Address BARNES HOSPITAL Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

Clavin D. McNamee

Licensed Embalmer No.

3024

P. O. Address.....

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.