

FILED AUG 25 1944 818

Registration District No. Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Bethesda Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Joseph Carol Bailey

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased December 23 - 1942  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

1	7	18	hr. min.
---	---	----	----------

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

10. Usual occupation Infant

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Joseph Lee Bailey

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

14. Maiden name Mary Worth

15. Birthplace Sioux Falls South Dakota  
(City, town, or county) (State or foreign country)

16. (a) Informant J.L. Bailey

(b) Address Festus, Mo.

17. (a) Burial (b) Date thereof 8-13-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Festus, Missouri

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd

19. (a) AUG 15 1944 (b) J. F. Brueck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 50

(a) State Missouri (b) County Jefferson

(c) City or town Festus  
(If outside city or town limits, write "RURAL")

(d) Street No. Rural  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 11 year 1944 hour 3:30 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from 8-11-44 to 8-11-44 that I last saw him alive on 8-11-44 and that death occurred on the date and hour stated above.

Immediate cause of death: Enteritis

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

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

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: \_\_\_\_\_

Of operations: \_\_\_\_\_

Of autopsy: examined (coroner certified)

Duration

2

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

(c) 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)

(c) Means of injury \_\_\_\_\_

23. Signature W. B. Barber (M. D. or other)

Address 4600 Maryland Date signed 8/14/44

8802

8802

---

**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 *Johan Aguirre*  
Licensed Embalmer No. *3348*  
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, fact should be so stated above.**