

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2149

FILED JAN 16 1947

State File No. _____

Registration District No. 310

Primary Registration District No. 3058

Registrar's No. 1

1. PLACE OF DEATH:

(a) County St. Charles
(b) City or town St. Charles
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2012 North Main
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME George W. Bailey

3. (b) If veteran, name war NIL 3. (c) Social Security No. NIL

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife Susie (Harmon) Bailey 6. (c) Age of husband or wife if alive 73 years
7. Birth date of deceased October 20 1862
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
84 2 11 hr. min.

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

10. Usual occupation Laborer

11. Industry or business American Car & Fdy Co

12. Name George Bailey

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

14. Maiden name Justice

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

16. (a) Informant Mrs. Irene Werremeyer

(b) Address 2012 N. Main-St. Charles, Mo.

17. (a) burial (b) Date thereof Jan 4-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove St. Charles, Mo.

18. (a) Signature of funeral director H. O. Dallmeyer & Sons Co.

(b) Address 800 N. 2nd-St. Charles, Mo.

19. (a) 1-6-47 (b) Jannie Hamelton
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Charles
(c) City or town St. Charles
(If outside city or town limits, write "RURAL")
(d) Street No. 2012 North Main
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 1
year 1947 hour 9:30 minute P. M.

21. I hereby certify that I attended the deceased from Nov 5 1946 to Jan 1 1947,
that I last saw him alive on Dec, 1946,
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Carcinoma of Stomach 2 yrs
Due to _____

Gen. Arteriosclerosis
Due to _____

Other conditions _____
(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 _____

23. Signature A. P. Erich Schindler (M. D. or other) _____

Address St. Charles, Mo. Date signed 1/3/47

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed JAN 14 1947

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.....

Joseph I. Laine
Licensed Embalmer No. *4189*

P. O. Address.....

St. Louis

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *Del*

Registration District No. *310*

Primary Registration District *3058*

Registrar's No. *2*

1. PLACE OF DEATH:

(a) County *St. Charles*
(b) City or town *St. Charles*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(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

George W. Bailey

3. (b) If veteran,
name war

3. (c) Social Security
No.

4. Sex *M*

5. Color on *W*
race

6. (a) Single, widowed, married,
divorced *Wid*

6. (b) Name of husband or wife

6. (c) Age of husband or wife if
alive *20* years

7. Birth date of deceased

Oct 20 1961
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

84

hr. min.

9. Birthplace

(City, town, or county)

(State or foreign country) *Ill.*

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

(City, town, or county)

(State or foreign country)

14. Maiden name

15. Birthplace

(City, town, or county)

(State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal)

(b) Date thereof

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) *Jan 6 1947* (b) *Francis Hammett*
(Day received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

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

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Jan* year *1947* hour *10* minute *15* M.

21. I hereby certify that I attended the deceased from *1947* to *1947*

that I last saw him *alive* on *Jan 6 1947* and that death occurred on the date and hour stated above.
Immediate cause of death

Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 (M. D. or other)

Address Date signed

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

SUPPLEMENTARY

2149