

FEDERAL BUREAU OF INVESTIGATION  
National Office of Vital Statistics  
FILED AUG 23 1948

UNITED STATES DEPARTMENT OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 27483  
Registrar's No. 7429

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis Mo  
(b) City or town St. Louis Mo  
(c) Name of hospital or institution St. Charles  
(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

Harry Bailey  
3. (b) If veteran, name and service number 3. (c) Social Security No.

5. Color of hair White 6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive

7. Birth date of deceased (Month) (Day) (Year)

8. AGE (Years) (Months) (Days) If less than one day (hr) (min)

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

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) Buried (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews Cem

18. (a) Signature of funeral director Romand Mortuary Service

(b) Address Manchester Ave.

19. (a) AUG 25 1948 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis Mo  
(c) City or town St. Louis Mo (If outside city or town limits, write "RURAL")  
(d) Street No. 921 Cherokee (If rural, give location)  
(e) Citizen of foreign country? (Yes or No) No  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH Month August Day 13 Year 1948 hour 8 M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death CHRONIC OCCLUSION  
CHRONIC SEPSIS  
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  
Signature John J. Brown (M. D. or other)  
Address St. Louis Mo Date signed 8/23/48

7429

### 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 Ralph W. Henson

Licensed Embalmer No. 3721

P. O. Address, St. Louis, Mo.

**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.**