

FILED MAY 23 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18042

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 864

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lemay 23		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lemay 23	
d. FULL NAME OF HOSPITAL OR INSTITUTION 820 Regina Ave.		d. STREET ADDRESS (If rural, give location) 820 Regina Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) Allen b. (Middle) B. M. c. (Last) Bailey			4. DATE OF DEATH (Month) (Day) (Year) April 8, 1949		
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH June 17, 1881	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months 7 Days 23
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) labor		10b. KIND OF BUSINESS OR INDUSTRY Axelson Co.		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME Joshua Bailey	13b. MOTHER'S MAIDEN NAME Lucinda Smith	14. NAME OF HUSBAND OR WIFE Father Bailey
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT'S SIGNATURE OR NAME Father Bailey	ADDRESS 820 Regina Ave.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yr
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chr. Interstitial Nephritis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) worry, Exposure to work DUE TO (c) Bronchitis 59 yr old		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Laryngismus Stridulus		109 days	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 592X
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) C. H. Brusemeyer M.D.	23b. ADDRESS 762 Lemay Ferry Rd	23c. DATE SIGNED 4-10-49
24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 4-11-49	24c. NAME OF CEMETERY OR CREMATORY Park Lawn Cmt
24d. LOCATION (City, town, or county) (State) Lemay Mo		

DATE REC'D BY LOCAL REG. 4-11-49	REGISTRAR'S SIGNATURE Thurid L...	25. FUNERAL DIRECTOR'S SIGNATURE Fendler Und. Co.	ADDRESS 7420 Michigan
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(Licensed Embalmer's Institution on Reverse Side)

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

0918
12/12/12

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed W E Morris

Licensed Embalmer No. 3360

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.