

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED OCT 7 1949

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State File No. 31572  
Registrar's No. 7948

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_

1. PLACE OF DEATH  
a. COUNTY \_\_\_\_\_  
2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).  
a. STATE Missouri b. COUNTY 25

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis c. LENGTH OF STAY (in this place) no  
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Senath 4

d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital d. STREET ADDRESS (If rural, give location) N.R.

3. NAME OF DECEASED a. (First) Oscar b. (Middle) MMN c. (Last) Bailey 4. DATE OF DEATH (Month) (Day) (Year) Sept. 12, 1949

5. SEX male 6. COLOR OR RACE white 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 8. DATE OF BIRTH Oct. 22, 1891 9. AGE (In years last birthday) 57 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown 10b. KIND OF BUSINESS OR INDUSTRY \_\_\_\_\_ 11. BIRTHPLACE (State or foreign country) Senath, Missouri 12. CITIZEN OF WHAT COUNTRY? 6

13a. FATHER'S NAME Sam C. Bailey 13b. MOTHER'S MAIDEN NAME Anna Bohannan 14. NAME OF HUSBAND OR WIFE Mildred

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 497-05-3174 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mildred Bailey, Senath, Missouri

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, asthma, etc. It means the disease, injury, or complication which caused death.  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: (a) Pericardium of Descending Aorta  
ANTECEDENT CAUSES DUE TO (b) \_\_\_\_\_  
DUE TO (c) \_\_\_\_\_  
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION \_\_\_\_\_ 19b. MAJOR FINDINGS OF OPERATION \_\_\_\_\_ 20. AUTOPSY? YES  NO

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) 410

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) \_\_\_\_\_ 21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK  21f. HOW DID INJURY OCCUR? 153X

22. I hereby certify that I attended the deceased from 8-11-49, 1949, to 9-12-49, 1949, that I last saw the deceased alive on 9-12-49, 1949, and that death occurred at 9:30 P.m., from the causes and on the date stated above.

23a. SIGNATURE F.R. Bradley M.D. (Degree or title) 23b. ADDRESS Barnes Hospital 23c. DATE SIGNED 9-12-49

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE 9-13-49 24c. NAME OF CEMETERY OR CREMATORY \_\_\_\_\_ 24d. LOCATION (City, town, or county) (State) Reston, Arkansas

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE SEP 14 1949 J.B. Lasater 25. FUNERAL DIRECTOR (Name and Address) St. Louis Mortuary Service Inc. 4104 Manchester Ave. St. Louis 10, Mo.

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

**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 *J. Allen Davis Jr*

Licensed Embalmer No. *4053*

P. O. Address *St Louis 10. M*

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.