No. 300
10.48

FILED JAN 28 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2839

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 23

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis
c. LENGTH OF STAY (In this place) 12 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5322 St. Louis Ave,

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ST Louis 2069
d. STREET ADDRESS (If rural, give location) 5322 ST Louis AVE

3. NAME OF DECEASED (Type or Print) a. (First) SARA b. (Middle) c. (Last) BAILEY

4. DATE OF DEATH (Month) (Day) (Year) January 3, 1953

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR Months	Days	If UNDER 24 HRS. Hours	Min.
female	white	widowed 2	January 26 '70	83				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY Invalid
11. BIRTHPLACE (State or foreign country) CASEYVILLE, ILL
12. CITIZEN OF WHAT COUNTRY? U.S

13a. FATHER'S NAME PETER GRIEVE SR.
13b. MOTHER'S MAIDEN NAME WANDLESS ELIZIBETH GRIEVE
14. NAME OF HUSBAND OR WIFE William BAILEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. none
17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs Gladys Haddick 4343 Vincent

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, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension Uremia Pneumonia
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 See 7 1950
19b. MAJOR FINDINGS OF OPERATION Coronary Occlusion
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) none
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) none m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? none 4209

22. *I hereby certify that I attended the deceased from* 12-16, 1952, *to* 1-3-, 1953, *that I last saw the deceased alive on* 1-2-, 1953, *and that death occurred at* 12:50 A m., *from the causes and on the date stated above.*

23a. SIGNATURE M F Harrison MD (Degree or title)
23b. ADDRESS 2239 N Kingshighway
23c. DATE SIGNED 1-3-53

24a. BURIAL, CREMATION, REMOVAL (Specify)
24b. DATE 1-5-53
24c. NAME OF CEMETERY OR CREMATORY GLENWOOD
24d. LOCATION (City, town, or county) (State) Collinsville ILL

DATE REC'D BY LOCAL REG. JAN 3 1953
REGISTRAR'S SIGNATURE J Carl Smith MD
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Collinsville
(Licensed Embalmer's Statement on Reverse Side)

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 [signature]

Licensed Embalmer No. 3577

P. O. Address [illegible]

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.