

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 11 1959

59-026373

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 6942** STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N. GRAND, ST. LOUIS, MO.		Length of stay in 1b 52 days	c. CITY OR TOWN ST. LOUIS Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET. ADM. HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2825 EASTON Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First DAVID Middle I. Last BAILEY			4. DATE OF DEATH Month JULY Day 25 Year 1959			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/7/12	9. AGE (last birthday) 46	IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE MAN		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) METROPOLIS, ILLINOIS		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME V. K. BAILEY		13b. MOTHER'S MAIDEN NAME EMMA OWENS		14. NAME OF HUSBAND OR WIFE JOSEPHINE BAILEY		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-2	16. SOCIAL SECURITY NO. 192-10-9296	17. INFORMANT VA HOSP. RECORDS, ST. LOUIS, MO.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF ESOPHAGUS WITH METASTASES		INTERVAL BETWEEN ONSET AND DEATH 4 MONTHS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 150x		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION VA	COUNTY	STATE
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21. I attended the deceased from 6/3/59 to 7/25/59 and last saw him him alive on 7/25/59 Death occurred at 7:00 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) Robert M. Smith M.D.	22b. ADDRESS VAH, ST. LOUIS, MO.	22c. DATE SIGNED 7-25-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7 29 59	23c. NAME OF CEMETERY OR CREMATORY National Cemeteries	23d. LOCATION (City, town, or county) (State) Jefferson Barracks Mo
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24. FUNERAL DIRECTOR A. H. Bunko 3506 Franklin	ADDRESS	25. DATE RECD. BY LOCAL REG. JUL 27 59	26. REGISTRAR'S SIGNATURE Robert M. Smith M.D. - S.P.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Hallan R. Williams

Licensed Embalmer No. 4926

5135 Saturo
P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

Handwritten scribbles

Handwritten scribbles