

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030929

FILED VS SEP 8 1959

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2305

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u> Length of stay in lb <u>7 Dys</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u> c. CITY OR TOWN <u>Kirkwood</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>440 Saratoga St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis CO. Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>440 Saratoga St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>CUE</u> Middle <u>Dallis</u> Last <u>BAILEY</u>			4. DATE OF DEATH Month <u>August</u> Day <u>22</u> Year <u>1959</u>			
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 18, 1886</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>3</u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>	10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	11. BIRTHPLACE (City and state or country) <u>Kirkwood, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>George Bailey</u>	13b. MOTHER'S MAIDEN NAME <u>Odelia Bailey</u>	14. NAME OF HUSBAND OR WIFE <u>Cecil Bailey</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>	16. SOCIAL SECURITY NO. <u>No.</u>	17. INFORMANT Address <u>Cecil Bailey 440 Saratoga St</u>
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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) <u>Pulmonary Atelectasis</u> DUE TO (b) <u>Bronchopneumonia</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>?</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic Heart Disease - Arteriolar Nephrosclerosis</u>		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 <u> </u> a.m. <u> </u> p.m. Month, Day, Year <u> </u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>
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20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from 8-19-1959 to and last saw her/him alive on 8-22-1959
 Death occurred at 4:05pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Paul W. Schaper M.D.</u>	22b. ADDRESS <u>601 S. Brentwood, Clayton, Mo.</u>	22c. DATE SIGNED <u>8-27-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/28.59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Father Dickson Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Crestwood Mo</u>
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24. FUNERAL DIRECTOR ADDRESS <u>John W. Hemphill 408 S. Fillmore Kirkwood 22. Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>8-27-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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 F. A. Green

Licensed Embalmer No. 2963

P. O. Addr. 4214 Belmont

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.