URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 30 1959

59-042382
STATE FILE NUMBER

MENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 210560

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST, LOUIS, MO.
Length of stay in 1b # 30 Yrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST, LOUIS CITY HOSP, #1
Inside Limits Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri
b. COUNTY
c. CITY OR TOWN ~~XXXXXX~~ St. Louis
Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 1735 Missouri
Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First STELLA Middle BAILEY Last PROCK
4. DATE OF DEATH Month NOV. Day 15 Year 1959
5. SEX Female
6. COLOR OR RACE White
7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☒
8. DATE OF BIRTH 10-17-06
9. AGE (last birthday) 53
IF UNDER 1 YEAR Months Days
IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Lady
10b. KIND OF BUSINESS OR INDUSTRY Retired
11. BIRTHPLACE (City and state or country) Missouri
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Henry Bailey
13b. MOTHER'S MAIDEN NAME Artie Conway
14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. Yes(Unk)
17. INFORMANT Artie Bailey, 1735 Missouri Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hepatic failure
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) acute viral Hepatitis superimposed
DUE TO (c) on Severe cirrhosis
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 581.1
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from SEPT. 22, 1959 to NOV. 15, 1959 and last saw her/him alive on NOV. 15, 1959
Death occurred at 4:50 am m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Nick Owen M.D. (Degree or title)
22b. ADDRESS 1515 LAFAYETTE AVE.
22c. DATE SIGNED 11/15/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 11/17/1959
23c. NAME OF CEMETERY OR CREMATORY West Fork
23d. LOCATION (City, town, or county) West Fork, Mo. (State)

24. FUNERAL DIRECTOR McLaughlin, 2301 Lafayette, (4) ADDRESS
25. DATE RECD. BY LOCAL REG. NOV 16 1959
26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

Amended Recd blood transfusion by the Director of Vital Records

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_____
Signature of Student Embalmer

Signed_____

Licensed Embalmer No._____

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp 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.