

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b DOA	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer Phillips Hosp.		d. STREET ADDRESS (If outside, give location) 3908 Sherman Pl.	

3. NAME OF DECEASED (Type or print) First Middle Last MARVIN TODD BAILEY			4. DATE OF DEATH Month Day Year Dec. 25, 1960		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/5/60	9. AGE (last birthday) 0	IF UNDER 1 YEAR Months Days 0 19

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) St. Louis Mo.	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Homer Bailey	13b. MOTHER'S MAIDEN NAME Ruth Sikes	14. NAME OF HUSBAND OR WIFE none	

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 Homer Bailey 3908 Sherman Pl.
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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>Polar Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	763.0

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 checked="" type="checkbox"/> NO <input 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	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 COUNTY STATE
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____.
 Death occurred at _____ on _____ the date stated above, and to the best of my knowledge, from the causes stated.

21a. SIGNATURE <i>Joseph M. Zuercher</i> (Degree or title)	21b. ADDRESS 1300 Clark	21c. DATE SIGNED 12-27-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12/27/60	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) Normandy Mo.
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24. FUNERAL DIRECTOR <i>Cullen & Kelly</i> ADDRESS 7267 Natural Bridge	25. DATE RECD. BY LOCAL REG. DEC 27 1960	26. REGISTRAR'S SIGNATURE <i>Paul Smith M.D.</i>
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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 me

or by _____, Student Embalmer No. _____

working under my personal supervision.

Not Embalmed

Student _____

Signature of Student Embalmer

Signed *James G. Lammers*

Licensed Embalmer No. *4142*

P. O. Address *St Louis*

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

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