MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

42796

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 42796

Township ..... Primary Registration District No. 1003 Registered No. 12585

City St Louis Mo (No. City Hospital St. ..... Ward)

2. FULL NAME Maine Bailer

(a) Residence. No. 504 Little Belway 23 Ward. St Louis Co
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Finish

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept Nuk 1855

7. AGE 74 YEARS MONTHS 3 DAYS Unknown If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Not Known

14. INFORMANT Chas Zobel
(Address) 3510 Dodier St

15. FILED DEC 27 1929 Max O Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 26 1929

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 8.20 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia
(Fractured Right Femur)
due to falling to street
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Accident
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) [signature] M.D.

12/27 1929 (Address) [signature] Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt Olive

DATE OF BURIAL Dec 30 1929

20. UNDERTAKER Fendler Mud Co

ADDRESS 7849 Mich Av

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.