

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City St. Louis Mo. (No. Insulation Hospital)

Registration District No. **791**
Primary Registration District No. **1002**

File No. 18290
Registered No. 4763
St. Ward)

2. FULL NAME

(a) Residence, No. 1015 Brooklyn St., 76 Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 1 1/2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE coloured 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 31, 1931

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
2 6 6

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Nil
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) St. Louis Mo. (STATE OR COUNTRY)

MOTHER 13. NAME John Bailey

14. BIRTHPLACE (CITY OR TOWN) St. Louis Mo. (STATE OR COUNTRY)

15. MAIDEN NAME Minnie Gibson

16. BIRTHPLACE (CITY OR TOWN) Mississippi (STATE OR COUNTRY)

17. INFORMANT Grace Besh (ADDRESS) 5103 Hurstfield

18. BURIAL, CREMATION, OR REMOVAL PLACE Green Wood DATE 5/11 1934

19. UNDERTAKER J.P. Richardson (ADDRESS) 2600 Jefferson

20. FILED MAY 10 1934 1934 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 6, 1934

I HEREBY CERTIFY, that I attended deceased from May 6, 1934 to May 6, 1934
I last saw him alive on May 6, 1934 Death is said to have occurred on the date stated above, at 3:30 P.M.
The principal cause of death and related causes of importance were as follows:

Bronchopneumonia Date of onset 4-22
1078

Other contributory causes of importance:

Name of operation None Date of 5/11/34
What test confirmed diagnosis? Clinical Was there an autopsy? Y

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? None Date of injury....., 19.....
Where did injury occur? None (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

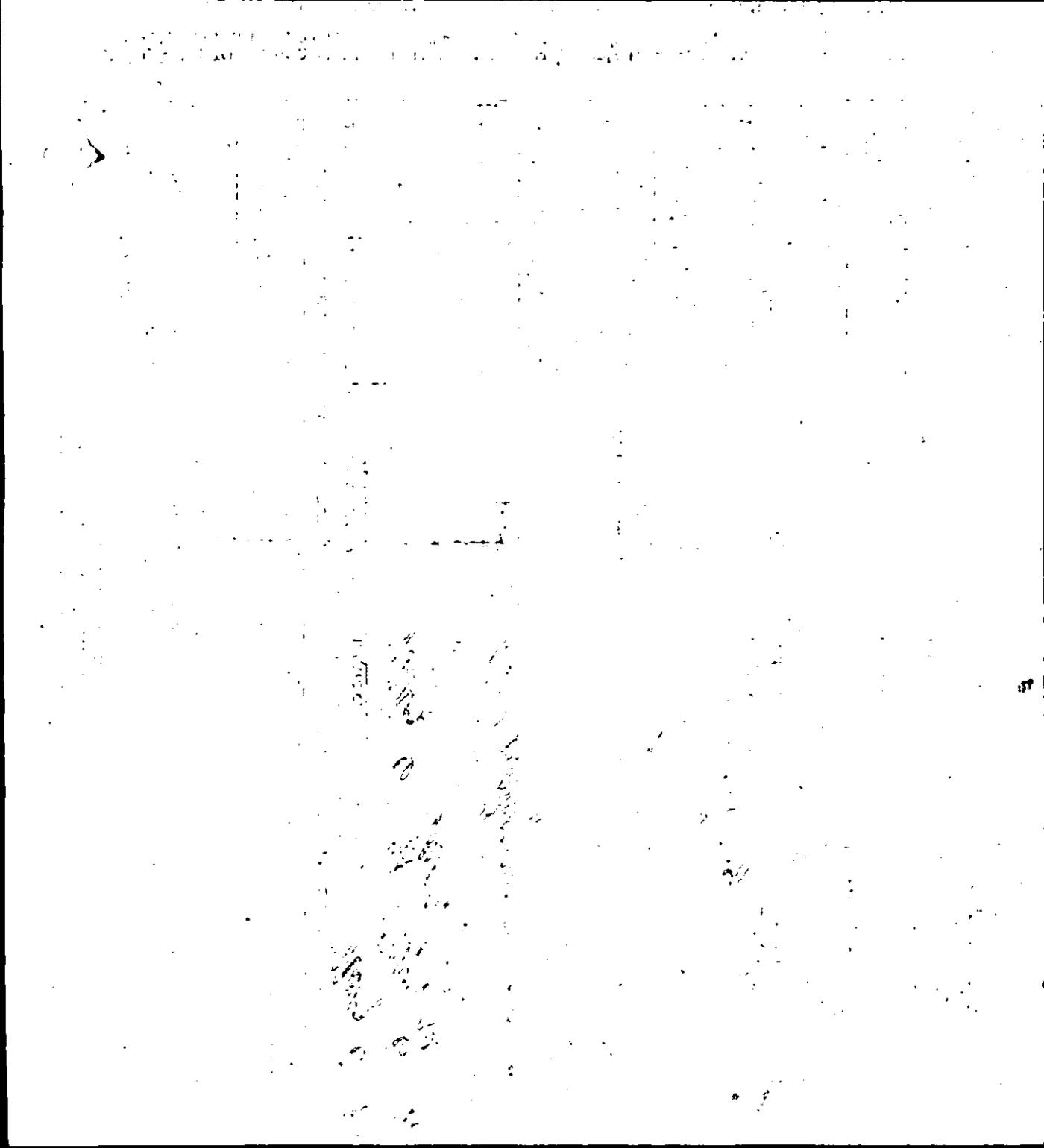
Manner of injury.....
Nature of injury.....

24. Was disease or injury directly related to occupation of deceased? If so, specify John S. Chamberlain (Signed) INSULATION HOSPITAL (Address)

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

JUN 19 1934



#2

DEPARTMENT OF COMMERCE

E. T. McGaugh, M. D.,

BUREAU OF THE CENSUS

Special Agent,

Jefferson City, Mo.

St Louis City

WASHINGTON 18290

4763

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Beatrice Bailey
Who died at Resurrection Hospital on May 6 - 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: 7 Years _____ Months _____ Days _____
Sex F Color or race B Single, married, widowed or divorced: _____

Date of birth _____ Age: Years 2 Months 6 Days 6

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

Date deceased last worked at this occupation: Month _____ Year _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: Broncho pneumonia
primary

Other contributory causes of importance none

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician _____

Address of physician _____

Signature of Registrar J. F. Bredek 9-15-34

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. 741
Primary Reg. Dist. No. 1003
Very truly yours,
E. T. McGaugh M.D.
Special Agent.

REPUBLIC OF CHINA
MINISTRY OF NATIONAL DEFENSE
GENERAL STAFF

SECRET

TO: THE CHIEF OF STAFF
FROM: THE DIRECTOR OF THE GENERAL STAFF
SUBJECT: [Illegible]

[Illegible text]

1934
5-18-39.0

[Illegible text]

[Illegible text]

[Illegible text]