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.

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

MAR 13 1939 3 791 1003

4640
Do not use this space.

1. PLACE OF DEATH
(a) County ..... Registration District No. 1333
(b) Township ..... Primary Registration District No. ..... Registered No. .....
(c) or City St. Louis Missouri (d) Street No. Enroute to City Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Roy Bailey
(a) Residence, No. 1912 Hickory St. 22
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 12, 1904

7. AGE YEARS 34 MONTHS 0 DAYS 28 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Chauffeur
9. Industry or business in which work was done, as 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) (STATE OR COUNTRY) Ross Oklahoma

FATHER
13. NAME Hamilton Bailey
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Unknown

MOTHER
15. MAIDEN NAME Maryella Cooper
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Unknown

17. INFORMANT (ADDRESS) Robert H. Williams 4700 Washington Blvd.

18. BURIAL, CREMATION, OR REMOVAL PLACE Jefferson City Mo. DATE Feb. 12, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Albert H. Hoppe Inc. 4700 Washington Blvd.

20. FILED FEB 10 1939 J. F. Bredeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

No Physician in Attendance

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/9/39, 19

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 6:45 P.M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Aortic Stenosis with Concentric Hypertrophy of Heart	

Other contributory causes of importance:
Chronic Endocarditis

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? Yes

23. 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 .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) Alfred J. Perry, M. D.
(Address) Deputy Coroner

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed J. G. Sullivan

Licensed Embalmer No. 1122

P. O. Address 4704 Wash. Blv

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to con with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.