

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 23223
Registrar's No. 5668

LED AUG 25 1940
Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 mos 8 das
(Specify whether years, months or days)
In this community 35 years

3. (a) PRINT FULL NAME Dallas Dailey 407

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race Cal
6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife Florance Dailey 6. (c) Age of husband or wife if alive Dead years
7. Birth date of deceased apri 19 1884
(Month) (Day) (Year)

8. AGE: Years 56 Months 2 Days 9 If less than one day hr. _____ min. _____

9. Birthplace Union City Tenn
(City, town, or county) (State or foreign country)

10. Usual occupation Labon

11. Industry or business _____

MOTHER FATHER
12. Name Antley Dailey
13. Birthplace Union City Tenn
(City, town, or county) (State or foreign country)
14. Maiden name Lucinda E. ...
15. Birthplace Union City Tenn
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Carrie Eury
(b) Address 2524 N Jefferson
17. (a) Burial (b) Date thereof 5-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Green Wood

18. (a) Signature of funeral director J.P. Richardson
(b) Address 2625 ...
19. (a) JUL 3 1940 (b) J.F. Bradeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 19
(If outside city or town limits, write "RURAL")
(d) Street No. 4490 Laclede
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 28
year 1940 hour 1:05 minute _____ A. M.

21. I hereby certify that I attended the deceased from April 20, 1940, to June 28, 1940
that I last saw him alive on June 28, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Heart Disease Duration 4-5yrs

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature H.J. Seymour (M. D. or other)
Address 2601 North Whittier Date signed _____

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.

ET'CK ILL--A NE V BEMIC

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. D. Richardson*
Licensed Embalmer No. *2928*
P. O. Address *2625 Glasgow*

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 13 223

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 5668

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Dallas Dailey

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race col
6. (a) Single, widowed, married, divorced Widowed
6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
36 2 9 _____ h _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER { 12. Name _____
13. Birthplace _____
(City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 1-20-1941 (b) J F Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 28
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature V J Lyman (M. D. or other)
Address St Louis Mo Date signed _____

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

SUPPLEMENTARY

