

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29698

State File No.

8663 ✓

FILED OCT 13 1943

Registration District No. 318

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH:

(a) County ST LOUIS MO  
(b) City or town ST LOUIS MO  
(c) Name of hospital or institution: HOMER PHILLIPS HOSPITAL  
(d) Length of stay: In hospital or institution 20 YRS.  
In this community 20 YRS. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County ST LOUIS  
(c) City or town ST LOUIS  
(d) Street No. 200 EAST HAVEN ST  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Leila Bailey

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

4. FEMALE 5. Color or race C 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife JOHN 6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased 9-1-1883  
(Month) (Day) (Year)

8. AGE: Years 60 Months 0 Days 23 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name UNKNOWN

13. Birthplace ALABAMA  
(City, town, or county) (State or foreign country)

14. Maiden name UNKNOWN

15. Birthplace ALABAMA  
(City, town, or county) (State or foreign country)

16. (a) Informant John Bailey

(b) Address 200 East Haven St

17. (a) BURIAL (b) Date thereof 10-1-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dakdale Cemetery

18. (a) Signature of funeral director Bennie Lane  
(b) Address 3103 Washington

19. (a) SEP 30 1943 (b) J. Broder  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 25  
year 1943 hour 1 minute 58 P 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 Cerebral apoplexy

Due to 83

Other conditions (Includes pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) (c) Means of injury \_\_\_\_\_

23. Signature Deputy Coroner (M. D. or other) \_\_\_\_\_  
Address Deputy Coroner Date signed 9/29/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

10 46

**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.....

William C. McDowell....., Registered Apprentice No. ....  
working under my personal supervision.

Signed William C. McDowell

Licensed Embalmer No. 2114

P. O. Address.....

**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, fact should be so stated above.**