

FILED OCT 13 1944

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 8434

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Barnes Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7 days (Specify whether  
In this community Ella Bailey Dean.  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis <sup>96</sup>  
(c) City or town Glendale <sup>11</sup>  
(If outside city or town limits, write "RURAL") <sup>NRI</sup>  
(d) Street No. 1125 N. Berry Road.  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Ella Bailey Dean

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Widowed

(b) Name of husband or wife. Dr. Lee W. Dean. 6. (c) Age of husband or wife if alive years

7. Birth date of deceased. Jan. 27 1877  
(Month) (Day) (Year)

8. AGE: - Years Months Days If less than one day  
67 8 5 hr. min.

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

10. Usual occupation At home

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

MOTHER FATHER { 12. Name unknown Bailey.  
13. Birthplace unknown England  
(City, town, or county) (State or foreign country)  
14. Maiden name Anna Grant.  
15. Birthplace unknown England  
(City, town, or county) (State or foreign country)

16. (a) Informant Dr. I. W. Dean, Jr.

(b) Address 9559 Litzinger Rd.

17. (a) burial (b) Date thereof 10/5/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director C. R. Lupton & Sons.

(b) Address 7233 Delmar Blvd.

19. (a) OCT 3 1944 (b) J. F. Cudeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 2  
year 1944 hour 9 minute 40 P. M.

21. I hereby certify that I attended the deceased from SEPT. 25,  
1944 to OCT. 2, 1944;  
that I last saw her alive on OCT. 2, 1944;  
and that death occurred on the date and hour stated above.

Immediate cause of death Primary Carcinoma of the Lung <sup>6 mos.</sup>

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions Arteriosclerotic heart disease <sup>18 mos</sup>  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy Primary Carcinoma of the Lung

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 Robert C. Wenzel (M. D. or other) M.D.  
Address Barnes Hospital, Date signed 10/5/44

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

*James Cooper*

**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 *Carence H. Murray*  
Licensed Embalmer No. *4011*  
P. O. Address *St. Louis Mo*

**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.**