S. No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 4 1947

Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 32297

Registrar's No. 8779

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: DEACONESS HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 MONTH (Specify whether
In this community 17 YRS years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County ST LOUIS 96
(c) City or town WEBSTER GROVES MO 7
(If outside city or town limits, write "RURAL")
(d) Street No. 58 SUMMIT AVE. 4
(If rural, give location)
(e) Citizen of foreign country? N.R. (Yes or No) 1
If yes, name country —

3. (a) PRINT FULL NAME ANNIE CATHERINE BAILEY
3. (b) If veteran, name war NO
3. (c) Social Security No. NONE

4. Sex FEMALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced SINGLE
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased OCTOBER 14 1861 (Month) (Day) (Year)

8. AGE: Years 85 Months 11 Days 2 If less than one day — hr. — min.

9. Birthplace ST CHARLES CO (City, town, or county) MISSOURI (State or foreign country)
10. Usual occupation TEACHER RETIRED
11. Industry or business

MOTHER FATHER
12. Name GUSTAVUS BAILEY
13. Birthplace ST CHARLES CO-MISSOURI (City, town, or county) (State or foreign country)
14. Maiden name ELIZA McGLASSON
15. Birthplace PRINCE EDWARD CO. W. VIRGINIA (City, town, or county) (State or foreign country)

16. (a) Informant MRS ELLEN B. GALLAGHER
(b) Address 58 SUMMIT AVE. W.G.
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 19 1947 (Month) (Day) (Year)
(c) Place: burial or cremation BELLEFONTAINE CEM.
18. (a) Signature of funeral director Parker-Hud Co
(b) Address WEBSTER GROVES, MO.
19. (a) SEP 19 1947 (Date received local registrar) (b) J. F. Breick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 16 year 1947 hour — minute — A. M.

21. I hereby certify that I attended the deceased from Aug. 17 1947 to Sept 8 19..; that I last saw her alive on Sept 16 1947 and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Fracture of neck left femur — 8/17/47
Antecedent causes and arteriosclerosis
Heart disease
Other conditions (Include pregnancy within 3 months of death) Pneumonia
Major findings: Operations Hospital
Of autopsy

PHYSICIAN
Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence Aug 17 - 1947
Where did injury occur? Fat home - (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? No
While at work? No (Specify type of place) Means of injury Fell in room
23. Signature H. R. Gudrich M. D.
Address 192 Kodiak Date signed 9/14/47

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

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

NOV 21 1947

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 Leslie Welch

Licensed Embalmer No. 4395

P. O. Address Webster Groves 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.