S. No. 2
M—1/47
6-17-39

#29670

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2233

FILED FEB 9 1948

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 984

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

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 months-7days (Specify whether

In this community 66years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County odd

(c) City or town St. Louis 17 (If outside city or town limits, write "RURAL")

(d) Street No. 5800 Arsenal St., Memorial 9 (If rural, give location) 0

(e) Citizen of foreign country? no (Yes or No) 13

If yes, name country

3. (a) PRINT FULL NAME WILLIAM BAILEY

3. (b) If veteran, name war

3. (c) Social Security No. OAA

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Unknown

6. (b) Name of husband or wife unknown

6. (c) Age of husband or wife if alive years

7. Birth date of deceased February (Month) 5th (Day) Unknown (Year)

8. AGE: abt Years 83 Months Days If less than one day hr. min.

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

10. Usual occupation OAA

11. Industry or business

FATHER

12. Name James Bailey

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

MOTHER

14. Maiden name Phobie

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

16. (a) Informant M. Renard

(b) Address St. Louis City Hospital

17. (a) Anatomical Board (Burial, cremation, or removal) (b) Date thereof JAN 31 1948 (Month) (Day) (Year)

(c) Place: burial or cremation Anatomical Board

18. (a) Signature of funeral director [signature]

(b) Address 4104 MANCHESTER

19. (a) JAN 31 (Date received local registrar) (b) J. F. [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 19th year 1948 hour 8 minute 25 P M.

21. I hereby certify that I attended the deceased from 11/12/47 19 to January 19th 1948 that I last saw him alive on January 19th 1948 and that death occurred on the date and hour stated above.

Immediate cause of death - Acute circulatory collapse cause undetermined Probably Myocardial Disease

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

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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? (Specify type of place)

While at work? (e) Means of injury

23. Signature U.K. Park (M. D. or other)

Address 1515 Lafayette 1/19/48 Date signed

Jefferson City Printing Co.

(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.....

Licensed Embalmer No.....

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.