

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31293

State File No. _____

FILED SEP 19 1951

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BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>				
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		c. LENGTH OF STAY (In this place) <u>2 Days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>68 OR TOWN Kirkwood</u>		4683		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis State Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>445 N. Clay Ave.</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>ADELE</u> b. (Middle) _____ c. (Last) <u>BAILEY</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 20, 1951</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Sept. 9, 1886</u>		
9. AGE (In years last birthday) <u>64</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>11</u>		IF UNDER 1 YEAR Hours _____ Min. _____		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Wm. Bailey</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>William Bailey, Kirkwood, Mo.</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Encephalo malacia</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 ds. x</u> <u>2 ds. x</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____		21. HOW DID INJURY OCCUR? <u>232X</u>		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m. _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						
22. I hereby certify that I attended the deceased from <u>July 18</u> , 19 <u>51</u> to <u>July 20</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>July 20</u> , 19 <u>51</u> and that death occurred at <u>8:10a</u> m., from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>Clara Hyman MD</u>				23b. ADDRESS <u>5400 Arsenal St.</u>		23c. DATE SIGNED <u>7/20/51</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		24b. DATE <u>7/23/51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Crematory</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>SEP 23 1951</u>		REGISTRAR'S SIGNATURE <u>J. B. Foster</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Louis H. Bopp, Inc., Kirkwood, Mo.</u>				

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

6545

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.....

working under my personal supervision.

Student Embalmer No.....

Signed *Felix Lluand*

Signed.....
Student Embalmer

Licensed Embalmer No. *3034*

P. O. Address *Kukwood 22 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.