

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **21714**
Registrar's No. **5792**FILED JUL 2- 1952
BIRTH NO. **5000A** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Texas	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, MO	c. LENGTH OF STAY (In this place) 5 DAYS	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN EUNICE 1070	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CHILDREN'S		d. STREET ADDRESS (If rural, give location) 1	

3. NAME OF DECEASED (Type or Print) SHARON DEANNE BAILEY			4. DATE OF DEATH (Month) (Day) (Year) 6-21-52		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH 7-28-51		9. AGE (In years last birthday) 10 1/2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) HOUSTON, MO	
				12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME MARVIN J. BAILEY		13b. MOTHER'S MAIDEN NAME JANE SMITH		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME J. EGAN ADDRESS 500 So. Kings Highway	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia		DUE TO (b) Cystic Fibrosis of the Pancreas			
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS (SPECIAL TO MEMORANDUM)		Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? 58.72	

22. I hereby certify that I attended the deceased from **6-16, 1952**, to **6-21, 1952**, that I last saw the deceased alive on **6-21, 1952**, and that death occurred at **11:50pm.**, from the causes and on the date stated above.

23a. SIGNATURE Wm. G. Klingberg, MD (Degree or title)		23b. ADDRESS St. Louis Children's Hospital		23c. DATE SIGNED 6-21-52	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 6-22-52		24c. NAME OF CEMETERY OR CREMATORY Yinon Chapel	
24d. LOCATION (City, town, or county) Eunice		24e. LOCATION (City, town, or county) Eunice		24f. LOCATION (City, town, or county) MO	
DATE REC'D BY LOCAL REG. JUN 23 1952		REGISTRAR'S SIGNATURE J. Carl Smith, MD		FUNERAL DIRECTOR'S SIGNATURE Elbert Lee ADDRESS Fun Home Eunice Mo	

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Not Embalmed

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.

(Body taken by Father)