

FILED JUL 2 - 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

20148

State File No. \_\_\_\_\_

No. 300

10.48

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>5540</b>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>ST. LOUIS</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Jewish Hospital</b>				STREET ADDRESS (If rural, give location) <b>6 3407 WILLIAMS PLACE</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>ANNA</b>		b. (Middle) _____		c. (Last) <b>BAILEY</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>June 20, 1954</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>Feb. 15, 1883</b>	
9. AGE (In years last birthday) <b>71</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 YEAR Hours _____ Min. _____		12. CITIZEN OF WHAT COUNTRY? _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Missouri</b>			
13a. FATHER'S NAME <b>John Lindner</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Henry Bailey</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>499-01-4202</b>		17. INFORMANT'S SIGNATURE OR NAME <b>HELLEN GUCCIONE</b> ADDRESS <b>3407 WILLIAMS PL</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>CEREBROVASCULAR ACCIDENT</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>GENERALIZED ARTERIOSCLEROSIS</b> DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>CHRONIC NEPHRITIS</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>  <b>YRS</b>  <b>YRS</b>	
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) <b>331X</b>			
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"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <b>6/12, 1954</b> to <b>6/20, 1954</b> , that I last saw the deceased alive on <b>6/20, 1954</b> and that death occurred at <b>7:05 P.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Robert Korol, M.D.</b>				23b. ADDRESS <b>Jewish Hospital</b>		23c. DATE SIGNED <b>6/21/54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		24b. DATE <b>6-23-54</b>		24c. NAME OF CEMETERY OR CREMATORY <b>New Bethlehem Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>	
DATE REC'D BY LOCAL REG. <b>JUN 21 1954</b>		REGISTRAR'S SIGNATURE <b>J. C. Smith MD</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Stroot-Carroll</b>		ADDRESS <b>4600 Natural Bridge</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

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.....  
Signature of Student Embalmer

Signed

*John J. Haines*

Licensed Embalmer No. *410*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.