

FILED OCT 3 - 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30556

State File No. 7792

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>7792</b>			
1. PLACE OF DEATH a. COUNTY <b>None</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>					
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>Kirkwood 773</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer Phillips Hospital</b>				. STREET ADDRESS (If rural, give location) <b>346 Saratoga, Kirkwood</b>					
3. NAME OF DECEASED (Type or Print) <b>Sadie</b>		a. (First)		b. (Middle)		c. (Last) <b>Bailey</b>			
4. DATE OF DEATH		(Month) <b>9</b>		(Day) <b>1</b>		(Year) <b>55</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>April 13, 1888</b>			
9. AGE (In years last birthday) <b>67</b>		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 1 HR. Hours Min.			
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 <b>-----</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Kirkwood, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13a. FATHER'S NAME <b>Manassa Spears</b>		13b. MOTHER'S MAIDEN NAME <b>Sophia St. James</b>		14. NAME OF HUSBAND OR WIFE <b>Anton Bailey</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Clifford Bailey, 4729 Northland #</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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chronic Brain Syndrome Secondary to Senility</b>				DUE TO (b)				Undt.	
ANTECEDENT CAUSES  Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (c)					
II. OTHER SIGNIFICANT CONDITIONS  Conditions contributing to the death but not related to the disease or condition causing death.				<b>Malnutrition</b>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>794.X</b>						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) 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>4-25</b> , 19 <b>55</b> , to <b>9-1-55</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>9-1</b> , 19 <b>55</b> , and that death occurred at <b>1:20 pm.</b> , from the causes and on the date stated above.									
23a. SIGNATURE <b>Frank O. Richards</b>				(Degree or title) <b>M.D.</b>		23b. ADDRESS <b>2601 N. Whittier</b>		23c. DATE SIGNED <b>9-1-55</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>9/7/55</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Father Dickson Cem.</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>			
DATE REC'D BY LOCAL REG. <b>SEP 6 1955</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Cunningham &amp; Moore, 2405 Marcus Av</b>					

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

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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 K. Cunningham*

Licensed Embalmer No.....447

P. O. Address...2405 Marcu.....

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.