CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County Shelby

Township or Village Clarence or City Mo (NO. ____ St.; ____ Ward)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 827

Primary Registration District No. 45 06

File No. 33967

Registered No. 41

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Malvida Frances Bailey

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Female	White	Married

DATE OF BIRTH July 6th (Month) (Day) 1862 (Year)

AGE 55 yrs. 2 mos. 7 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Preacher

(b) General nature of industry, business, or establishment in which employed (or employer) —

BIRTHPLACE (City or town, State or foreign country) Ill.

PARENTS

NAME OF FATHER John Gillispie

BIRTHPLACE OF FATHER (City or town, State or foreign country) K. Y. ?

MAIDEN NAME OF MOTHER Barbara Burks

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ind

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Bailey

(ADDRESS) Clarence Mo

Filed Sept 24, 1917. W. M. Bayless REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept (Month) 13 (Day) 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from July 10, 1917, to Aug 12, 1917, that I last saw her alive on Aug 12, 1917, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Paralisis

(Duration) one yrs. ____ mos. ____ ds.

Contributory (SECONDARY)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. R. Daniel M. D.

Sept 22 1917 (Address) J R Daniel

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? —

Former or usual residence —

PLACE OF BURIAL OR REMOVAL Maplewood — DATE OF BURIAL 9-15-1917

UNDERTAKER E E Hopper — ADDRESS Clarence Mo

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., 1..... (Month) (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 191.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....,

that I last saw h..... alive on ....., 191.....,

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....ds.

Contributory .....
(SECONDARY)

.....(Duration).....yrs.....mos.....ds.

(Signed) ..... M. D.

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191.....
UNDERTAKER	**ADDRESS**

N. B.—Every item of information should be carefully ex[illegible] CAUSE OF DEATH in plain terms, so that it may be pr[illegible] Exact statement of OCCUPATION is v[illegible]