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

1 PLACE OF DEATH

County Shelby

Township Salt River — Registration District No. 830 — File No. 29349

or

Village ..... — Primary Registration District No. 6091 — Registered No. .....

or

City Shelbina (NO. ....., ... St.; ..... Ward)

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

2 FULL NAME Nina May Bailey

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	married

6 DATE OF BIRTH: July (Month) 2 (Day), 1882 (Year)

7 AGE: 37 yrs. 2 mos. 25 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer): ✓

9 BIRTHPLACE (City or town, State or foreign country): Shelbina, Missouri

PARENTS

10 NAME OF FATHER: Richard O'Donnell

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

12 MAIDEN NAME OF MOTHER: Jane C. Cross

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. R. W. O'Donnell

(Address) Shelbyville, Missouri

15 Filed Sept 22, 1919 — Mattie Doy, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept. (Month) 22 (Day), 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 1 —, 1916, to Sept 22, 1919, that I last saw h... alive on Sept 22, 1919, and that death occurred, on the date stated above, at 9:0' m.

The CAUSE OF DEATH* was as follows:

Recurrent Cancer of breast
50 W3

(Duration) 3 yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) ✓

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

(Signed) J. A. Jamison M. D.

Sept 22, 1919 (Address) Shelbina Mo

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

18 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

19 PLACE OF BURIAL OR REMOVAL: Shelbina Mo — DATE OF BURIAL: Sept. 23, 1919

20 UNDERTAKER: Ezra Peter — ADDRESS: Shelbina Mo

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CERTIFICATE OF DEATH

1 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 o
hospital or
give its NA
of street an

2FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

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

7 AGE

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

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

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

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

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address).....

15

Filed..... 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

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

17 I HEREBY CERTIFY, that I attended decea
....., 191....., to.....,
that I last saw h.....alive on.....,
and that death occurred, on the date stated above, at.....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

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

CONTRIBUTORY.....
(Secondary)
..... (Duration).....yrs.....mos.

(Signed).....

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

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

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

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

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

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BUR

20 UNDERTAKER	ADDRESS