

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

Do not use this space.

27075 <sup>D</sup>

6 1927

**1. PLACE OF DEATH**

County Harrison  
Township Harrison  
City (unnamed) (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 382  
Primary Registration District No. 5-131-

File No. 88  
Registered No. \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)  
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 15 - 1927

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, 1.0 hrs. or — min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work \_\_\_\_\_  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) West Plains  
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Henry Bailey

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Missouri  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Faith Crow

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Missouri  
(STATE OR COUNTRY)

14. INFORMANT Will Brown  
(Address) West Plains

15. FILED 9-15-27 Oph. Heinrich  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 15 1927

17. I HEREBY CERTIFY: That I attended deceased from Sept 10, 1927, to Sept 15, 1927.  
that I last saw him alive on Sept 15, 1927, and that death occurred, on the date stated above, at 10:20 A. M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

151 B - Prematurity  
159 161 A  
(duration) yrs. mos. da.  
CONTRIBUTORY (SECONDARY)  
(duration) yrs. mos. da.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH: \_\_\_\_\_

8 DID AN OPERATION PRECEDE DEATH: \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY: \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS: \_\_\_\_\_

(Signed) Eveland Bohrer, M. D.  
(Address) 9-15-1927

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Evergreen Cem. DATE OF BURIAL 9-15-1927

20. UNDERTAKER George P. Stopp ADDRESS West Plains

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

