MAR 19 1928

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

Do not use this space.

File No. 5445
Registered No. 1440

1. PLACE OF DEATH
County LACLEDE Registration District No. 444
Township Primary Registration District No. 4267
City LEBANON (No. , St. Ward)

2. FULL NAME SALLIE MARIE BAILEY

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) FEB. 8, 1928

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	17	

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) TULSA
(STATE OR COUNTRY) OKLA.

PARENTS

10. NAME OF FATHER GEO. W. BAILEY
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) WEST. VA.
12. MAIDEN NAME OF MOTHER ELLA KEPPLER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) OKLA.

14. INFORMANT GEO. W. BAILEY
(Address) LEBANON MO.

15. FILED 2/25, 19 28. J. W. Billings REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) FEB 25, 1928

17. I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1928, to Feb. 25, 1928, that I last saw h. ALIVE on Feb. 25, 1928, and that death occurred, on the date stated above, at 7 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broncho-Pneumonia
10 7 H
(duration) yrs. mos. 5 ds.

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Tulsa, Okla.
DID AN OPERATION PRECEDE DEATH? no. DATE OF
WAS THERE AN AUTOPSY? no.
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) W. A. Hamilton, M. D
, 19 (Address) Lebanon, Mo.

*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: LEBANON CEMETARY — DATE OF BURIAL: 2-25-1928
20. UNDERTAKER: PALMER — ADDRESS: LEBANON

MISSOURI STATE BOARD OF HEALTH
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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REG. RARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1. PLACE OF DEATH
County Laclede Registration District No. 449 File No.
Township Primary Registration District No. 4267 Registered No. 1440
City Lebanon (No. , St. Ward)

2. FULL NAME Sallie Marie Bailey

(a) Residence. No. St., Ward
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
F	W.	S.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-8-1928

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, 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)
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 4/2, 19 28 J. W. Billings REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-25 1928

17. I HEREBY CERTIFY, That I attended deceased from , 19 to , 19
that I last saw h alive on , 19 , and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broncho Pneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Primary
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) , M. D
, 19 (Address)

*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	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY