

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

Do not use this space.

24314

1. PLACE OF DEATH

County Henry
Township Mutler
City McFall (No. _____)

Registration District No. 313
Primary Registration District No. 5432

File No. _____
Registered No. 5
St. _____ Ward) _____

2. FULL NAME Rosina M 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)

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

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

7. AGE

YEARS

MONTHS

DAYS

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

64

9

12

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)

Indiana

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

unknown

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

unknown

14.

INFORMANT

(Address)

John E Bailey
McFall, Mo

15.

FILED

7/31 1924 D. F. A. Westfall

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-13-29 19

17.

I HEREBY CERTIFY, That I attended deceased from July 7
July 13 1929 July 13 1929
that I last saw her alive on July 13 1929, and that
death occurred, on the date stated above, at 11/30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer Rectum

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH McFall Mo

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) D. R. Treasure, M. D.

July 13 1929 (Address) McFall

*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

Medford Minnesota

7-16-29 19

20. UNDERTAKER

ADDRESS

S. S. Cropper Pattonburg Mo

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.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF BIRTH

County Sentry
Township Miller
City (No. City) (No. City) (No. City)

Registration District No. 313
Primary Registration District No. 9432

File No.
Registered No. 9-
Sl. Ward

2. FULL NAME

(a) Residence. No. St. Ward.
(Usual place of abode)

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 1st 1864

7. AGE YEARS MONTHS DAYS IF LESS than day, hrs. or min.
64 9 12

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)

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 7/31 1929 Dr. F. K. Weithall REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 13 1929

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

5-24314