

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.

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

Do not use this space.

32751

1. PLACE OF DEATH

County Stone  
Township Flat Creek  
City                      (No.                     )

Registration District No. 1096  
Primary Registration District No. 6247

File No.                       
Registered No. 5  
St.                      Ward                     

2. FULL NAME

Len Bailey

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

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

widower

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

Don't know name

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

May 1857

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day,                      hrs. or                      min.

72

X

8. OCCUPATION OF DECEASED

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

Farmer

(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

Levi Bailey

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ind.

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Don't know

14.

INFORMANT  
(Address)

Jas Mullett  
Reeds Spring Mo

15.

FILED

9/14 29 Chas. H. Carson  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 2 19 29

17.

I HEREBY CERTIFY That I attended deceased from Aug 13, 19 29, to Sept 2, 19 29, that I last saw him alive on Sept 2, 19 29, and that death occurred, on the date stated above, at 5:20 A m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Typhoid fever

CONTRIBUTORY (SECONDARY)

(duration)                      yrs.                      mos. 18 ds.

(duration)                      yrs.                      mos.                      ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

8 DID AN OPERATION PRECEDE DEATH? no DATE OF                     

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) L. S. S. M. D.

9/3/29 (Address) Reeds Spring 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

DATE OF BURIAL

Yocumford cemetery

Sept 4 1929

20. UNDERTAKER

ADDRESS

Mrs Hattie Stahl Reeds Spring Mo

