

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.

APR 30 1930

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

Do not use this space.

9508

56

File No. _____
Registered No. _____
Ward _____

1. PLACE OF DEATH

County Marion Registration District No. 547
Township Mason Primary Registration District No. 3229
City Hannibal (No. 1728) Fulton Ave

2. FULL NAME

Sarah Bailey
(a) Residence. No. 1728 Fulton Avenue 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

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 7 1930

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF E. R. W. Bailey

17. I HEREBY CERTIFY, That I attended deceased from Mon 2nd, 1930, to Mon 7, 1930 that I last saw her alive on Mon 7, 1930, and that death occurred, on the date stated above, at 3:25 P.m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 15 - 1858

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
71 9 19

Nephritis interstitial
131
132A

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

Don't know (duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Illinois

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

10. NAME OF FATHER Richard Waters

18. WHERE WAS DISEASE CONTRACTED 132A
IF NOT AT PLACE OF DEATH _____

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

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

12. MAIDEN NAME OF MOTHER unknown Cline

WAS THERE AN AUTOPSY? _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) unknown Illinois

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) A. B. Blue M. D.
, 19 (Address) 5714 Page St. Hannibal

14. INFORMANT Ethan R. W. Bailey
(Address) 1728 Fulton Ave Hannibal, 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.

15. FILED March 8 3 E. C. Cassins REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St. Claret DATE OF BURIAL March 9 1930

20. UNDERTAKER Wm. M. Smith ADDRESS 902 Broadway Hannibal, Mo

