

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

Do not use this space.

27282

1. PLACE OF DEATH

County Maries
Township Johnson
City _____ (No. _____)

Registration District No. 546
Primary Registration District No. 5735

File No. _____
Registered No. 10
St. _____ Ward _____

2. FULL NAME

Louisa Jane Bailey
(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred 60 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND'S (OR) WIFE'S NAME E. P. Bailey

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 11 - 1844

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
86 2 0

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Maries Co
(STATE OR COUNTRY) Mo

10. NAME OF FATHER Dont Know

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Maries Co
(STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Dont Know

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

14. INFORMANT D. W. Bailey
(Address) Vicksy Mo

15. FILED Aug 14 1930 Sam A. Warner
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-11 1930

17. I HEREBY CERTIFY, That I attended deceased from July 23 to Aug 11, 1930
that I last saw her alive on Aug 10, 1930, and that death occurred, on the date stated above, at 6 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic interstitial nephritis

131 (duration) 3 yrs 1 mos 1 ds.

CONTRIBUTORY (SECONDARY)

129 (duration) _____ yrs _____ mos _____ ds.

18. WHERE WAS DISEASE CONTRAICTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical

(Signed) Willoughby Bailey, M. D.

8/11, 1930 (Address) St James 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

Home DATE OF BURIAL 8-12 1930

20. UNDERTAKER

W. E. Luchter ADDRESS St James Mo

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

