

MAR 25 1936

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

Do not use this space.

9110

1. PLACE OF DEATH

County Alchison
Township Benton
City Alchison (No. 19)

Registration District No. 19
Primary Registration District No. 8024

File No. 9110
Registered No. 9110
St. Alchison Ward 1

2. FULL NAME

(a) Residence, No. 19 St. Alchison Ward 1
(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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John Bailey
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 31-1860
7. AGE YEARS 77 MONTHS 2 DAYS 8 If LESS than 1 day, hrs. min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. House Wife
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Alchison, Mo (STATE OR COUNTRY)

13. NAME James J. Bailey

14. BIRTHPLACE (CITY OR TOWN) Scotland (STATE OR COUNTRY)

15. MAIDEN NAME Elizabeth M. Kay

16. BIRTHPLACE (CITY OR TOWN) Yonkers, N.Y. (STATE OR COUNTRY)

17. INFORMANT Donald Bailey (ADDRESS) Alchison, Mo

18. BURIAL, CREMATION, OR REMOVAL

PLACE Cherwood DATE Mar 12 1936

19. UNDERTAKER C. C. Brigham (ADDRESS) Alchison, Mo

20. FILED 3-10 19 36 Mary J. Chastain Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-4 19 36

22. I HEREBY CERTIFY, That I attended deceased from 3-5 19 36 to 3-9 19 36

I last saw him alive on 3-9 19 36 Death is said to have occurred on the date stated above, at 10:50 P.M.

The principal cause of death and related causes of importance were as follows:

Bronch. Pneumonia Date of onset 3-4 36

1072

Other contributory causes of importance:

Name of operation none Date of Mar 4

What test confirmed diagnosis? Microscopic Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? None Date of injury Mar 4 19 36

Where did injury occur? Home (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury None

Nature of injury None

24. Was disease or injury in any way related to occupation of deceased?

If so, specify None

(Signed) Queen Hunter M. D.

(Address) Alchison, Mo.

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

PLACE OF DEATH.

County Atchison Registration District No. 19 File No. _____
 Township Templeton Primary Registration District No. 5023 Registered No. _____
 City _____ (No. _____ St. _____ Ward _____)
 FULL NAME Una Hunter Bailey
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 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

4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
MARRIED, WIDOWED, OR DIVORCED HUSBAND OF OR WIFE OF	
DATE OF BIRTH (MONTH, DAY AND YEAR)	
YEARS	MONTHS
DAYS	If LESS than 1 day, _____ hrs. or _____ min.

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 _____

PLACE OF BIRTH (CITY OR TOWN) _____
 STATE OR COUNTRY _____

NAME OF FATHER _____

BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

INFORMANT _____
 Address _____

FILED 3-10-1936 Mary J. Chandler
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-9 19 36

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

_____ (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTUTORY _____
 (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
	19

20. UNDERTAKER	ADDRESS

V. S. NO. 2.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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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1. PLACE OF DEATH

County.....
Township.....
City..... (No. St.

Registration District No.
Primary Registration District No.

File No.
Registered No.

2. FULL NAME

(a) Residence. No. St. Word.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos.

How long in U. S., if of foreign birth? yrs. mos.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

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)

PARENTS

14. INFORMANT (Address)

15. FILED 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

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

17.

I HEREBY CERTIFY, That I attended deceased from 19..... to 19....., 18....., that I last saw h. alive on death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

(date) yrs. mos.
(date) yrs. mos.

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)

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSE (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDE, HOMICIDE. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BU

20. UNDERTAKER

ADDRESS