

OCT 21 1936

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

33352

1. PLACE OF DEATH

County Death
 Township Suburana
 City Oran

Registration District No. 870
 Primary Registration District No. 6069

File No.
 Registered No.
 St. Ward

2. FULL NAME

(a) Residence. No. Oran 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

Negro

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

Single (illegitimate)

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

Father of child. E. L. Bailey

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

Aug 6th/36

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

6

8. OCCUPATION OF DECEASED

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

child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Oran Mo.

(STATE OR COUNTRY)

10. NAME OF FATHER

E. L. Bailey

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Oran Mo.

(STATE OR COUNTRY)

12. MARRIED NAME OF MOTHER

Annie May Harris

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Miss

(STATE OR COUNTRY)

14.

INFORMANT

(Address)

Walter Grace Parker

Oran Mo.

of May Harris

15.

Filed 10/9/36

J. P. Cickman

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 12th 1936

I HEREBY CERTIFY, That I attended deceased from

, 19...., to, 19....

that I last saw him alive on, 19...., and that death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Colitis

CONTRIBUTORY (SECONDARY)

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)

H. J. Welch

, 19

(Address)

St. Louis, 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

McMullin Cemetery

8/13 1936

20. UNDERTAKER

None

ADDRESS

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

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.

1. PLACE OF DEATH

County..... Registration District No..... File No.....
Township..... Primary Registration District No..... Registered No.....
City..... (No.....) St..... 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. (If nonresident give city or town and State)
da. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

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)

14. INFORMANT (Address)

15. FILED 19.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19 :

17. I HEREBY CERTIFY, That I attended deceased from that I last saw h..... alive on....., 19....., to....., 19....., and that death occurred, on the date stated above, at.....
THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

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.)

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DATE OF BURIAL

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ADDRESS