

REC'D MAY 10 1939

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

13647
Do not use this space.

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 399
 (b) Township 1st Primary Registration District No. 1002
 (c) City H. C. MO (d) Street No. H. C. Gen Hosp Registered No. 1401
 (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (e) Length of residence in city or town where death occurred yrs. mos. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mike Bailey
 (a) Residence, No. 1720 Montgall (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (insert the word) A.

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April-11-1873

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
65 11 18

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. school
 9. Industry or business in which work was done, as 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) (STATE OR COUNTRY) MO

FATHER
 13. NAME Mike Bailey
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

MOTHER
 15. MAIDEN NAME Laura Harris
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) Record Clerk H. C. Gen Hosp

18. BURIAL, CREMATION OR REMOVAL Wt. Washington DATE 4-5-39

19. FUNERAL DIRECTOR (ADDRESS) Wm. B. Campbell

20. FILED Apr 2 1939 A. B. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-29-39

22. I HEREBY CERTIFY, That I attended deceased from 3-29-39, 1939, to 3-31-39, 1939.
 I last saw him alive on 3-31-39, 1939. Death is said to have occurred on the date stated above, at 10:30 a.m.
 The principal cause of death and related causes of importance were as follows:
Route Urinary occlusion
7412
 Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) P. J. D. Mangan M. D.
 (Address) H. C. Gen Hosp
H. C. MO

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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.