FILED FEB 17 1940

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

3224
Do not use this space.

1. PLACE OF DEATH
(a) County Nodaway
(b) Township or (c) City Maryville
Registration District No. 628
Primary Registration District No. 3031
Registered No. 8
(d) Street No. St. Francis Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Wm Augustus Gailey
(a) Residence, No. Tarkio Mo. St.
(Usual place of abode, if no street address, write county or city)
Tarkio Mo.
(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
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 Ursula E. Warner
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 1 - 1865
7. AGE: Years 74 Months 3 Days 23 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Day Laborer
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) Bloomfield Iowa

FATHER
13. NAME Shep. Gailey
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER
15. MAIDEN NAME Reis
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Mrs. W. A. Gailey Tarkio Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE Home Cemetery Tarkio Mo. DATE Jan 26, 1940
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Jas. M. Davis Tarkio Mo
20. FILED Jan 26, 1940 Manus E. Clardy Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 24, 1940
22. I HEREBY CERTIFY, that I attended deceased from Jan. 24, 1940, to Jan. 24, 1940
I last saw him alive on Jan. 24, 1940. Death is said to have occurred on the date stated above, at 10:10 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Acute Obstruction of Bowels	
Acute Retention of Urine	

Other contributory causes of importance:

Name of operation None Date of
What test confirmed diagnosis? Clinical Was there an autopsy? No

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? No
If so, specify
(Signed) Chas. F. Lee, M. D.
(Address) Maryville, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.

1222

RECEIVED
District Health Officer No. 11,
District File Number 240-156
Date Filed FEB 14 1940

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 Jno. M. Harris

Licensed Embalmer No. 2394

P. O. Address Sarkin, Mo.

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

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

. 2B
21-40
X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9224

Registration District No. 625 Primary Registration District No. 3021 Registrar's No.

1. PLACE OF DEATH:
(a) County Nodaway
(b) City or town Maryville Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Wm Augustus Bailey
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Mu
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 74 Months 3 Days 23 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 24 year 1930 hour minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19;
that I last saw him alive on , 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute Obstruction bowels	1
Due to Acute Retention urine	2
Due to Cause unknown Possible carcinoma	
Other conditions (Include pregnancy within 3 months of death)	
Major findings Of operations	
Of autopsy	

N.B. Patient came to Hosp with no history & was moribund.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (e) Means of injury

23. Signature Chas T. Bell (M. D. or other)
Address Maryville Mo Date signed

SUPPLEMENTARY

S-3224