

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

22998

State File No.

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

- (a) County Sullivan Co
(b) City or town Humphreys
(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 15 yrs. years, months or days)

3. (a) PRINT FULL NAME CLIFFORD DARRIL BAILEY

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years

7. Birth date of deceased Aug. 24 1924 (Month) (Day) (Year)

8. AGE: Years 15 Months 10 Days 1 If less than one day hr. min.

9. Birthplace Sullivan Co mo (City, town, or county) (State or foreign country)

10. Usual occupation School child

11. Industry or business

12. Name Oscar Bailey

13. Birthplace Sullivan Co mo (City, town, or county) (State or foreign country)

14. Maiden name Rose Harmon

15. Birthplace Sullivan Co mo (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Oscar Bailey

(b) Address Humphreys mo

17. (a) Burial (b) Date thereof July 2 1940 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Humphreys mo

18. (a) Signature of funeral director P. K. Payne

(b) Address East mo

19. (a) July 2 1940 (b) Lulu Scott (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Sullivan

(c) City or town Humphreys (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 28 year 1940 hour 9 minute P. 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.

Immediate cause of death by accidental electrocution Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence June 28 1940

(c) Where did injury occur? Humphreys, Sullivan, Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? near home

While at work? No (Specify type of place) (e) Means of injury Electric current

23. Signature J. C. Roberts, Coroner (M. D. registrar)

Address Pollock, Mo. Date signed

RECEIVED

District Health Officer No. 10

District File Number 7-40-1401

Date Filed JUL 11 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 _____

Licensed Embalmer No. 3400

P. O. Address Gaiters

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.