DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 40068

Registration District No. 949 — Primary Registration District No. 6225 — Registrar's No. 10

DEC 11 1940

1. PLACE OF DEATH:
(a) County Wright
(b) City or town Union Twp
(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 years, months or days) In this community 5 years in Dec.

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Wright
(c) City or town Rural
(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 Charles Baillie
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 Married
6. (b) Name of husband or wife Lula Baillie
6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased Oct (Month) 1 (Day) 1875 (Year)

8. AGE: Years 64 | Months 10 | Days 29 | If less than one day hr. min.

9. Birthplace Dundee (City, town, or county) Scotland (State or foreign country)
10. Usual occupation Farming
11. Industry or business
MOTHER FATHER
12. Name Dave Baillie
13. Birthplace (City, town, or county) Scotland (State or foreign country)
14. Maiden name Doris Kraw
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant's own signature Lula Baillie
(b) Address Grove Springs Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 1 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Lebanon Mo
18. (a) Signature of funeral director W. E. Hausman
(b) Address Lebanon Mo
19. (a) 8-30-40 (Date received local registrar) (b) C M Hamell (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 29 year 1940 hour 10 minute 45a M.
21. I hereby certify that I attended the deceased from Apr. 20, 1940 to Aug. 6, 1940 that I last saw him alive on Aug. 14, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma upper stomach & oesophagus	8 month
Due to: cancer	
Due to: Cardiac decompensation	
Other conditions (Includes pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature O. L. Bohrer (M. D. or other) D.O.
Address LEBANON Missouri Date signed 8/30/40

(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.

RECEIVED
District Health Officer No. 6,
District File Number 1240-1962
Date Filed DEC 6 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

myself, Registered Apprentice No.

working under my personal supervision.

Signed W. E. Halmiari

Licensed Embalmer No. 4107

P. O. Address Lebanon Mo

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

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

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. 40068

Registration District No. 949 Primary Registration District No. 6226 Registrar's No.

1. PLACE OF DEATH:
(a) County Wright
(b) ~~City or town~~ Rubinow Twp
(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 Chas Baillie
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 M
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 64 Months 10 Days 29 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)
MOTHER
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 Aug day 20 year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19; that I last saw h alive on , 19; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Carcinoma upper Stomach & oesophagus
Due to Cancer
Due to # N. M. D. #
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations 46
Of autopsy

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature O. S. Bohren (M. D. or other)
Address Lebanon Mo Date signed

SUPPLEMENTARY

1940
S-40068