

No. 2  
-1-4-41  
-17-39  
X28390

FILED MAY 10 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **14700**

Registration District No. 365 Primary Registration District No. 5511 Registrar's No. 4

1. PLACE OF DEATH:  
(a) County Wheeler  
(b) City or town Wheatland  
(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 Mo. (b) County Wheeler  
(c) City or town Wheatland  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Patricia Ann Bailey  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April day 7  
year 1941 hour 8 minute 00 M.

4. Sex female 5. Color or race wh  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years  
7. Birth date of deceased March 20, 1940  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Mar 23 - 1941 to April 2 - 1941;  
that I last saw her alive on April 2 - 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebro-Spinal Meningitis Duration 3 days

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace Wheatland Mo.  
(City, town, or county) (State or foreign country)

Due to Had Bronchial Pneumonia  
Meningitis probably due to  
Due to Pneumococcus infection  
Duration of Pneumonia 7 days

10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
12. Name Arthur Bailey  
13. Birthplace Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Ruth Hood  
15. Birthplace Mo.  
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

16. (a) Informant Ruth Bailey  
(b) Address Wheatland Mo  
17. (a) burial (b) Date thereof 4/4/41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Gardner Care  
18. (a) Signature of funeral director J. Luckey  
(b) Address Wheatland Mo.  
19. (a) Apr 3/41 (b) Mrs. A. S. Johnston  
(Date received local registrar) (Registrar's signature)

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?  
326 (Specify type of place) (e) Means of injury \_\_\_\_\_  
While at work? \_\_\_\_\_  
23. Signature A. S. Johnston (M. D. or other) \_\_\_\_\_  
Address Wheatland Mo. Date signed 4-5-41

(Licensed Embalmer's Statement on Reverse Side)

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

204

RECEIVED

District Health Officer No. 7,

District File Number 5-41-808

Date Filed 5-8-41

**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 J.P. Luckey

Licensed Embalmer No. 2989

P. O. Address Wheatland, W. Va.

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, fact should be so stated above.