

No. 2
4-13-40
5-17-39
PI X23159

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS
FILED MAY 8 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

14311

State File No. _____

Registrar's No. 321

Registration District No. 212

Primary Registration District No. 2001

39
2
6
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County GREENE
 (b) City or town Springfield
 (c) Name of hospital or institution: St. Johns Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community 7 years
 years, months or days

3. (a) PRINT FULL NAME WILLIAM E. BAILEY

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Ida Bailey 6. (c) Age of husband or wife if alive 65 years
 7. Birth date of deceased Feb 25 1875
 (Month) (Day) (Year)

8. AGE: Years 67 Months 2 Days 0
 If less than one day _____ hr. _____ min.

9. Birthplace June City, Kansas
 (City, town, or county) (State or foreign country)

10. Usual occupation Florist

11. Industry or business Florist

12. Name B. F. Bailey

13. Birthplace Unknown Miss. 1
 (City, town, or county) (State or foreign country)

14. Maiden name Thompson

15. Birthplace Unknown 9 Unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ida Bailey

(b) Address 1205 Bronville

17. (a) Burial (b) Date thereof 4-29-42
 (Burial, cremation, or removal) (Month) (Day), (Year)

(c) Place: burial or cremation Forest Park - Jasper Mo.

18. (a) Signature of funeral director W. H. ...

(b) Address Springfield Mo.

19. (a) Feb 25 1875 (b) W. H. Bailey
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Greene
 (c) City or town Springfield
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1205 Bronville
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month April day 25
 year 1942 hour 8:30 minute _____ P.M.

21. I hereby certify that I attended the deceased from 4/22, 1942, to 4/25, 1942
 that I last saw him alive on 4/25, 1942
 and that death occurred on the date and hour stated above.

Immediate cause of death Ruptured Gall Bladder
 Due to Cholelithiasis

Due to _____
 Other conditions 176
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy Ruptured Gall bladder calculus impacted in common duct

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 W. H. Bailey (M. D. or other) _____

Address Hallmark Bldg. Spfld Date signed 4/26/42

PHYSICIAN

Underline the cause to which death should be charged statistically.

784

(Licensed Embalmer's Statement on Reverse Side)

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, fact should be so stated above.

Max Rhodes
4071
Springfield
X