S. No. 2
M—9-4-41
v. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 13 1942 141

Registration District No.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

30460

State File No.

Primary Registration District No. 30 25

Registrar's No. 90

1. PLACE OF DEATH:
(a) County Howell
(b) City or town West Plains, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community 73 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Howell
(c) City or town West Plains Mo
(If outside city or town limits write "RURAL")
(d) Street No. 1 S Fairview
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Orilda Adley Bailey
3. (b) If veteran, name war V
3. (c) Social Security No.

4. Sex F 1 | 5. Color or race W | 6. (a) Single, widowed, married, divorced W 2

6. (b) Name of husband or wife J W Bailey
6. (c) Age of husband or wife if alive years
Birth date of deceased Oct 21 (Month) — 1868 (Day) (Year)

8. AGE: Years 73 | Months 8 | Days 27 | If less than one day (hr. min.)

9. Birthplace Howell Co. (City, town, or county) Mo (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
MOTHER FATHER
12. Name Wm Woodrell
13. Birthplace Arkansas (City, town, or county) (State or foreign country) 1
MOTHER
14. Maiden name Pamelia Dewart
15. Birthplace Arkansas (City, town, or county) (State or foreign country) 1
16. (a) Informant Chas Bailey
(b) Address West Plains Mo
17. (a) B (Burial, cremation, or removal) (b) Date thereof 7-20-42 (Month) (Day) (Year)
(c) Place: burial or cremation Howell
18. (a) Signature of funeral director Roberts
(b) Address West Plains Mo
19. (a) 9-7-42 (Date received local registrar) (b) Mil Harlan (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 18
year 42 hour 7 minut 50 M.
21. I hereby certify that I attended the deceased from Sept. 1941, 19 to July 1942.
that I last saw her alive on July 16 1942.
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Respiratory failure	
Due to Chronic Degeneration of Lungs, Pulmonary Phthisis	
Due to	
Other conditions (Include pregnancy within 3 months of death) Senility	
Major findings: Of operations	
Of autopsy	

13 f 1

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 R A Sparks (M. D.)
Address West Plains Mo. Date signed 9/2/1942

1125 (Licensed Embalmer's Statement on Reverse Side)

Sparks

RECEIVED
District Health Officer No. 5,
District File Number 104200
Date Filed 10/7/42

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. 3433

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.