DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 2996

FILED FEB 10 1944

Registration District No. 19

Primary Registration District No. 3023

Registrar's No. 19

1. PLACE OF DEATH:
(a) County Henry
(b) City or town Clinton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution N Water St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community Life
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Henry
(c) City or town Clinton
(If outside city or town limits, write "RURAL")
(d) Street No. N Water
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Alma S. Bailey

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Wm Thomas Bailey

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

7. Birth date of deceased 12 (Month) 28 (Day) 1880 (Year)

8. AGE: Years 63 | Months 0 | Days 16 | If less than one day ___ hr. ___ min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Frank Barnes
(b) Address Clinton Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 1944 (Month) (Day) (Year)
(c) Place: burial or cremation Lynnway Cem

18. (a) Signature of funeral director Fred Wilkinson
(b) Address Clinton Mo

19. (a) January 17 1944 (Date received by registrar) Georgia Kitchen (Registrar's signature)

1965

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 14
year 1944 hour 5 minute 00 A. M.

21. I hereby certify that I attended the deceased from 1-12 1944, to 1-13 1944, that I last saw h[er] alive on 1-13 1944 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pneumonia	3 Days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

PHYSICIAN — Underline the cause to which death should be charged statistically.

Major findings:
Of operations
Of autopsy

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 K J Powell (M. D. or other)
Address Clinton Mo Date signed 1/17/44

(Licensed Embalmer's Statement on Reverse Side)

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

OCT 19 1945

District Health Officer No. 7

District File Number 1-44-133

Date Filed 2-9-44

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 Fred W Wilkerson

Licensed Embalmer No. 2478

P. O. Address Clinton N

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, fact should be so stated above.

No. 2B
—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. D-FEB

Registration District No. 187 Primary Registration District No. 3023 Registrar's No. 19

1. PLACE OF DEATH:

(a) County Henry

(b) City or town Clinton (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

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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Alma S. Bailey

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife

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

7. Birth date of deceased Dec 28 (Month) (Day) (Year)

8. AGE: Years 62 Months 0 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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 January day

year 1944 hour 6 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.

SUPPLEMENTARY

	Duration
Immediate cause of death Pneumonia Lobar.	3 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 108	
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 R. J. Powell M. D. (Attending Physician or Coroner)

Address Clinton Mo Date signed 2/6

FILED

2996