

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 12 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11463

State File No. _____

Registration District No. 200

Primary Registration District No. 3041

Registrar's No. 25

1. PLACE OF DEATH:

(a) County Macon
(b) City or town macon
(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 _____ (Specify whether _____)
In this community _____ years, months or days.

3. (a) PRINT FULL NAME

Esther May Bailey

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May 31 1937
(Month) (Day) (Year)

8. AGE: Years 6 Months 10 Days 5 If less than one day _____ hr. _____ min.

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

10. Usual occupation School girl

11. Industry or business _____

12. Name Dennis J. Bailey

13. Birthplace Macon Co. Mo. (City, town, or county) (State or foreign country)

14. Maiden name Opal Barnes

15. Birthplace Macon Co. Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Opal Bailey

(b) Address Macon, Mo.

17. (a) Burial (b) Date thereof 3/7/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Burial Macon, Mo.

18. (g) Signature of funeral director Stephen J. Gooding

(b) Address Macon, Mo.

19. (a) 3/29/44 (b) Jora W. Hunkler
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon
(c) City or town Macon (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5 year 1944 hour one minute 00 P.M.

21. I hereby certify that I attended the deceased from Mar 5 1944 to _____ 1944;

that I last saw her alive on Mar 5 1944; and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive stage of cerebrospinal meningitis
Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 6

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? _____

While at work? _____ (Specify type of place) (e) Means of injury 2

23. Signature P. E. Marshall (M. D. or other P.D.)

Address Macon, Mo. Date signed Mar 23 1944

RECEIVED

District Health Officer No. 10

District File Number 4-44-233

Date Filed APR 8 1944

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.

Registrar's No. 24-

Address..... Date signed.....

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

11463