

FILED MAY 8 1944

Registration District No. **2038**

1. PLACE OF DEATH:
(a) County **Linn**
(b) City or town **Brookfield**
(c) Name of hospital or institution: **Brookfield Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 to 2 days**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Linn**
(c) City or town **Shelby**
(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 **LAURA BAILEY MCGHEE**
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 2**
6. (b) Name of husband or wife **B.F. MCGHEE** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **(Nov) 11 - 3 - 1859**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **4** day **12**
year **1944** hour **1** minute **45 P.M.**
21. I hereby certify that I attended the deceased from **4-9**, 19**44**, to **4-12**, 19**44**
that I last saw her alive on **4-12**, 19**44**
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
84 5 8 hr. _____ min.

Immediate cause of death
Chronic Myocarditis Duration **5 yrs**
Hypertension **10 yrs**
Chronic Int. Nephritis **12 yrs**

9. Birthplace **McLean Co. Ill. 1**
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)
None

10. Usual occupation **Housewife**

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN **JW**
Underline the cause to which death should be charged statistically.

MOTHER FATHER { 12. Name **H. H. Bailey**
13. Birthplace **Monroe Co. Indiana 1**
(City, town, or county) (State or foreign country)

{ 14. Maiden name **Elizabeth H. H. H. H.**
15. Birthplace **Monroe Co. Indiana 1**
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

16. (a) Informant **ELSIE SPENCER**
(b) Address **Ponca City, Okla.**

(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)

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **5-13-44**
(Month) (Day) (Year)
(c) Place: burial or cremation **Beav Branch, Linn Co.**

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature **J. H. H. H.** (M. D. or other)
Address **Brookfield Mo** Date signed **4/3**

18. (a) Signature of funeral director **Reek Funeral Home**
(b) Address **Brookfield Mo**
19. (a) **4-14-1944** (b) **H. H. H. H.**
(Date received local registrar) (Registrar's signature)

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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 E. A. Larson

Licensed Embalmer No. 4037

P. O. Address Bucklin, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

471-41-4