

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

21448
 Do not use this space.

FILED JUL 7 1944

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1. PLACE OF DEATH

(a) County Dallas Registration District No. 92
 (b) Township Sherman Primary Registration District No. 5-3-5-2 Registered No. 105
 (c) City Plad Rural (d) Street No. _____ St. _____
 (e) Length of residence in city or town where death occurred 5 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME JOHN G BAILEY

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Minerva Bailey
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 25 1869
 7. AGE YEARS 74 MONTHS 6 DAYS 13 If LESS than 1 day, _____ hrs. or _____ min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ray Co Mo

FATHER 13. NAME Issac W Bailey

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

MOTHER 15. MAIDEN NAME Mary A Jones

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

17. INFORMANT (ADDRESS) Minerva Bailey

18. BURIAL, CREMATION, OR REMOVAL PLACE Plad DATE 6-11 1944

19. FUNERAL DIRECTOR (NAME) (ADDRESS) R B Jones
Buffalo Mo

20. FILED 6-23 1944 R B Jones
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 8 1944

22. I HEREBY CERTIFY, That I attended deceased from DK June 3, 1944 to _____, 19____
 I last saw him alive on June 3, 1944 Death is said to have occurred on the date stated above, at 8:10 pm.
 The principal cause of death and related causes of importance were as follows:

Chronic Coronary disease Date of onset 1938

Other contributory causes of importance:
Artery Disease
Fracture of Hip DK June 1

Name of operation none Date of _____
 What test confirmed diagnosis? usual Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____

(Signed) G B Blumner M. D.
 (Address) Buffalo Mo

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

3000

1371

RECEIVED
District Health Officer
District File Number 6-44-758
Date Filed 7-6-44

Date Filed
Dist.
1
F
DISTRICT HEALTH OFFICER
NO. 7

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 *Leonard R. Jones*

Licensed Embalmer No. *2508*

P. O. Address *Buffalo, N.Y.*

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, above space should be left blank.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July
Registrar's No. 184

Registration District No. 96

Primary Registration District No. 5349

1. PLACE OF DEATH:

(a) County Dallas
(b) City or town Rural
(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 _____
In this community _____
years, months or days

3. (a) PRINT FULL NAME John S. Barley
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased Nov. 25 1869
(Month) (Day) (Year)

8. AGE: Years 74 Months 6 Days 3 If less than one day _____ min.
9. Birthplace Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____
11. Industry or business _____
12. Name _____
13. Birthplace _____
(City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____
(b) Address _____
19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 28
year 1944 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____
_____ 19____
that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Coronary Disease
Duration _____

Due to _____
Due to arterio sclerosis
Other conditions Fracture of hip!
(Include pregnancy within 3 months of death)
Major findings: Of operations none
Of autopsy none
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) no
(b) Date of occurrence May 28, 1944
(c) Where did injury occur? at home
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, or in other place?
Hip fracture was only contributory
While at work? no (Specify type of place) (e) Means of injury fall
23. Signature W. H. Summers (M. D. or other) _____
Address _____ Date signed 7-12-44

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

SUPPLEMENTAL

6-29-44

21448