No. 2
5-43
17-39
X36671

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. 27703

FILED SEP 13 1944

Registration District No. 1208 Primary Registration District No. 4197 Registrar's No. 84

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: West 2nd St. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ✓ (Specify whether In this community 30 years. years, months or days)

2. USUAL RESIDENCE OF DECEASED: 38

(a) State MO (b) County Henry 3
(c) City or town Clinton (If outside city or town limits, write "RURAL") 0
(d) Street No. W. Court St. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country ✓

3. (a) PRINT FULL NAME Thomas Francis Baley

3. (b) If veteran, name war ✓ 3. (c) Social Security No. None

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced widower

6. (b) Name of husband or wife Mrs. Wallace Baley 6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased June 21 (Month) (Day) 1858 (Year)

8. AGE: Years 86 Months 1 Days 7 If less than one day hr. min.

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

10. Usual occupation Retired Bridge Mover

11. Industry or business Work Civil Flood

FATHER
12. Name John Baley
13. Birthplace Ind (City, town, or county) ? (State or foreign country)

MOTHER
14. Maiden name Sarah Brown
15. Birthplace Ky (City, town, or county) ? (State or foreign country)

16. (a) Informant Fred Baley
(b) Address Clinton MO

17. (a) (Burial, cremation, or removal)? (b) Date thereof 7/30/44 (Month) (Day) (Year)
(c) Place: burial or cremation Clinton MO

18. (a) Signature of funeral director Lafayette Bradley
(b) Address Clinton MO

19. (a) Aug 5-1944 (Date received local registrar) (b) Homer N. Mott (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 28
year 1944 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from July 27, 1944, to July 28, 1944
that I last saw h alive on 19
and that death occurred on the date and hour stated above.

Immediate cause of death Acute myocarditis ✓ Duration

Due to ✓

Due to ✓

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy No

ADDITIONAL SUPPLEMENTARY INFORMATION REQUIRED

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 F. J. Hinckley M.D. (M. D. or other)
Address Clinton MO Date signed July 30 1944

1108

(Licensed Embalmer's Statement on Reverse Side)

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. 1898

P. O. Address Shutesbury Mass

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.

No. 2B
—5-43
I X36930

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Sept.

Registration District No. ____ Primary Registration District No. ____ Registrar's No. ____

1. PLACE OF DEATH:
(a) County Gentry
(b) City or town Stanberry
(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
In this community 30 Y years, months or days)

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 Thomas F. Bally
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 W
6. (b) Name of husband or wife ____
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased June 21 1858 (Month) (Day) (Year)
8. AGE: Years 86 | Months | Days | If less than one day ____ hr. ____ min.
9. Birthplace ____ (City, town, or county) ____ (State or foreign country)
10. Usual occupation ____
11. Industry or business ____
MOTHER FATHER
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) ____ (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)

SUPPLEMENTAL

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 26 1944 year ____ hour ____ 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.

	Duration
Immediate cause of death Acute nephritis	
Due to ____	
Due to ____	
Other conditions (Include pregnancy within 3 months of death) ____	
Major findings: Of operations ____	
Of autopsy ____	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 ____ (M. D. or other) ____
Address ____ Date signed ____

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

27703