

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14771

Registrar's No. 3

FILED MAY 5 1945
Registration District No. 379

Primary Registration District No. 42-14-6181

1. PLACE OF DEATH:

(a) County Sullivan
(b) City or town Rural Penn Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Near Green City
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community Life
years, months or days

3. (a) PRINT FULL NAME Jobe Acheal Bailey

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Laura Bailey 6. (c) Age of husband or wife if alive 74 years
7. Birth date of deceased May 29 1863
(Month) (Day) (Year)

8. AGE: Years 81 Months 10 Days 7 If less than one day
hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name John Bailey

13. Birthplace Don't know Ohio
(City, town, or county) (State or foreign country)

14. Maiden name Verida Matthews

15. Birthplace Montreal Canada
(City, town, or county) (State or foreign country)

16. (a) Informant Walter E. Bailey

(b) Address 1405 Columbia, Mo.

17. (a) Burial, cremation, or removal Green City Cemetery

(b) Date thereof April 10, 1945
(Month) (Day) (Year)

(c) Place: burial or cremation Green City Cemetery

18. (a) Signature of funeral director Pharm E. Hunt

(b) Address Green City

19. (a) 5-2-1945 (b) Laura Shaw-Deputy
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Sullivan
(c) City or town Green City
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 7
year 1945 hour 12:45 minute P M.

21. I hereby certify that I attended the deceased from 3:30
1945 to 4:7 1945
that I last saw her alive on 4-7 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
Duration 1 week

Due to _____

Due to _____

Other conditions. (Include pregnancy within 3 months of death)
Pneumonia

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 _____

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) _____

23. Signature of physician Pharm E. Hunt
Address Green City

24. Signature of physician Pharm E. Hunt
Address Green City

25. Signature of physician Pharm E. Hunt
Address Green City

26. Signature of physician Pharm E. Hunt
Address Green City

27. Signature of physician Pharm E. Hunt
Address Green City

28. Signature of physician Pharm E. Hunt
Address Green City

29. Signature of physician Pharm E. Hunt
Address Green City

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

RECEIVED

District Health Officer No. 10

District File Number 5-45-729

Date Filed MAY 4 1945

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 Archie W. Wade

Licensed Embalmer No. 3037

P. O. Address Green Lake, Wis.

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.