

DEPARTMENT OF COMMERCE
BUREAU OF VITAL RECORDS
FILED JUL 10 1946
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20852**

Registration District No. **170**

Primary Registration District No. **5632**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **LACLEDE**
(b) City or town **OSAGE TWP**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **OAKLAND MO 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 **11 YRS** years, months or days

3. (a) PRINT FULL NAME **William C. BAILAR**

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

4. Sex **MO** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **WIDOWED**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **JAN 21 - 1855** (Month) (Day) (Year)

8. AGE: Years **91** Months **4** Days **18** If less than one day _____ hr. _____ min.

9. Birthplace **PICKERIN OHIO** (City, town, or county) (State or foreign country)

10. Usual occupation **RETIRED ENGINEER**

11. Industry or business _____

12. Name **ADAM, L. BAILAR** 4

13. Birthplace **GERMANY** (City, town, or county) (State or foreign country)

14. Maiden name **SARAH COONCE**

15. Birthplace **ENGLAND** (City, town, or county) (State or foreign country)

16. (a) Informant **W. C. Bailar**

(b) Address **OAKLAND MO**

17. (a) **BURIAL** (b) Date thereof **6-11-46** (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **BONES CEM**

18. (a) Signature of funeral director **PALMER'S**

(b) Address **LEBANON, MO**

19. (a) **6-12-46** (b) **Ors Frankfurter** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JUNE** day **9** year **1946** hour **3** minutes **30 P.M.**

21. I hereby certify that I attended the deceased from **May 21** 19**46**, to **June 9** 19**46**, that I last saw him alive on **May 21** 19**46**, and that death occurred on the date and hour stated above.

Immediate cause of death **Seimily - hypertensive pneumonia** Duration _____
Due to **Cerebral apoplexy** 30 days
Due to _____

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

Major findings: Of operations **1/3** Of autopsy _____
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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature **Wm. J. Walsja** (M. D. or other) **M.D.**
Address **Lebanon, Mo** Date signed **6/11/46**

152 (Licensed Embalmer's Statement on Reverse Side)

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

Received 7-5-46
Laclede County Health Unit
File No. 6-46-89
Date Filed 7-8-46

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 W. P. Palmer
Licensed Embalmer No. 2208
P. O. Address Lebanon mo

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.