

No. 2
-5-43
-17-39
X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36630

State File No. _____

FILED NOV 21 1946
Registration District No. _____

Primary Registration District No. 2000

Registrar's No. 873

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
812 E. McDaniel
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 812 E. McDaniel
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME SAMANTHA BAILEY

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

4. Sex female 5. Color or race Negro 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Herschel Bailey 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 13 1881
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 3 18 _____ hr. _____ min.

9. Birthplace Dade County Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business _____

MOTHER FATHER

12. Name Esol Johnson

13. Birthplace Middle Tenn.
(City, town, or county) (State or foreign country)

14. Maiden name Sally Busbee

15. Birthplace Dresden Tenn.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Lilla Price

(b) Address 812 E. McDaniel

17. (a) burial (b) Date thereof 11-3-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln

18. (a) Signature of funeral director H. V. Smith

(b) Address 702 N. Jefferson

19. (a) 11-6-46 (b) W. J. Handley M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 1
year 1946 hour 6 minute 25 A.M.

21. I hereby certify that I attended the deceased from _____
19 _____ to Oct 31, 19 46
that I last saw her alive on Oct 31, 19 46
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis, acute

Due to none

Due to none

Other conditions Arthritis, multiple, bedridden for 6 yrs
(Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy none 93A

Duration
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? _____

While at work _____ (Specify type of place) (f) Means of injury _____

23. Signature W. H. Selsky (M. D. or other) M.D.

Address Springfield Mo Date signed 11-2-46

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

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.....

Herbert X Smith

Licensed Embalmer No. *4286*

P. O. Address..... *Springfield*

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.