

FILED DEC 31 1946
Registration District No. 3035

Primary Registration District No. 3035

1. PLACE OF DEATH:

(a) County Kosciusko
(b) City or town Lexington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Water Tower Hill
(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 JAMES C. BAILEY

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

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

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

7. Birth date of deceased April (Month) 25 (Day) 1923 (Year)

8. AGE: Years 23 Months 7 Days 2 If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business at home

12. Name Conley Bailey

13. Birthplace Ray, Mo (City, town, or county) (State or foreign country)

14. Maiden name Miss McCordendall

15. Birthplace Lexington, Mo (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Lela Gabbatt

(b) Address Lexington, Mo

17. (a) Burial (b) Date thereof 11-30-46 (Month) (Day) (Year)

(c) Place: burial or cremation Lexington, Mo

18. (a) Signature of funeral director Thelma G. Gabbatt

(b) Address Lexington, Mo

19. (a) 15 Dec 46 (b) Thelma G. Gabbatt (Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Kosciusko
(c) City or town Lexington 54
(If outside city or town limits, write "RURAL") 3
(d) Street No. City 2
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 27
year 1946 hour 2 minute 40 AM

21. I hereby certify that I attended the deceased from Nov 27, 1946, to _____, 19____;

that I last saw h _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death. Rheumatic heart disease with congestive failure Duration 2 yrs

Due to _____

Due to _____

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

Major findings: Of operations 9510

Of autopsy _____

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 0

23. Signature John W. Ward (M. D. or other)

Address Lexington, Mo Date signed 12/27/46

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 12-28-46

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.....

Licensed Embalmer No. 2983

P. O. Address Leamington, 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.