

S. No. 2
-11-10-39
v. 5-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 18 1947

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **16242**
Registrar's No. **77**

Registration District No. **360**

Primary Registration District No. **6225**

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

1. PLACE OF DEATH:
(a) County Vernon
(b) City or town Warshaw
(c) Name of hospital or institution State Hospital #32
(d) Length of stay: In hospital or institution 4 yrs 6 mo - 26 days
In this community 4 years 6 months 26 days

8. (a) PRINT FULL NAME JESSE BAILEY
3. (b) If veteran, **(c) Social Security**
5. Color or race White
6. (a) Single, widowed, married, divorced, or separated Single
6. (b) Name of husband or wife None
6. (c) Age of husband or wife if alive None years
7. Birth date of deceased Oct 14 1908
(Month) (Day) (Year)

8. AGE: Years 38 Months 5 Days 26
If less than one day hr. min.

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

10. Usual occupation Farming

11. Industry or business
12. Name Benjamin Bailey
13. Birthplace Mo
14. Maiden name Mary Williams
15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital record
(b) Address Nevada, Mo

17. (a) Removal Removal **(b) Date thereof** 4-10-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Warshaw, Mo

18. (a) Signature of funeral director Reed Funeral Home
(b) Address Warshaw, Missouri

19. (a) 4-10-47 **(b)** Kathryn Yancey
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Benton
(c) City or town Warshaw
(d) Street No. R 3
(e) If foreign born, how long in U. S. A. None years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 8
year 1947 hour 4 minute 35 P.M.
21. I hereby certify that I attended the deceased from 4-5-47 to 4-8-47
that I last saw him alive on 4-8-47
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis
Due to None
Other conditions None
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: None
Of operations: None
Of autopsy: None
Underline the cause to which death should be charged statistically.

22. If death was due to external cause, fill in the following:
(a) Accident, suicide, or homicide (specify) None
(b) Date of occurrence None
(c) Where did injury occur? None
(d) Did injury occur in or about home, on farm, in industrial place, in public place? None
23. Signature W. H. Hall **(M.D. or other)** None
Address Nevada, Mo **Date signed** 4-10-47

RECEIVED
District Health Officer No. 7.
District File Number 3-47-474
Date Filed 4-17-47

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 John P. Reser
Licensed Embalmer No. 440,08
P. O. Address Warren

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, above space should be left blank.