

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 17 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7801

State File No. _____
Registrar's No. 56

Registration District No. 38 Primary Registration District No. 3006

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

1. PLACE OF DEATH:
(a) County Boone
(b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Ellis Fischel State Cancer Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 20 days (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Boone 89
(c) City or town ORRICK (If outside city or town limits, write "RURAL") 0
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? NO (Yes or No) 1
If yes, name country _____

3. (a) PRINT FULL NAME Bailey William Thomas
3. (b) If veteran, _____ name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 21st
year 1948 hour 11 minute 05 PM.
21. I hereby certify that I attended the deceased from
12/20/47 to 2/21/48
that I last saw him alive on 2/21/48
and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race white
6. (a) Single, widowed, married, divorced 1
6. (b) Name of husband or wife Mollie Bailey 6. (c) Age of husband or wife if alive 80 years
7. Birth date of deceased Feb 6 1865
(Month) (Day) (Year)

Immediate cause of death:
Cardiac failure 1 wk
Due to cardiac invasion by tumor
Due to retroperitoneal carcinoma
Other conditions (Include pregnancy within 3 months of death) None

8. AGE: Years Months Days If less than one day
83 - 15 - - hr. - min.

Major findings: Above
Of operations: Cyst, rt. kidney
Of autopsy: Above
Underline the cause to which death should be charged statistically.

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

10. Usual occupation HARNESS MAKER

11. Industry or business _____

12. Name BRACK Bailey

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

14. Maiden name _____

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

16. (a) Informant Mollie Bailey
(b) Address ORRICK Mo.

17. (a) Burial (b) Date thereof 2 24 48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Orrick Mo
18. (a) Signature of funeral director Orrick Mo
(b) Address Orrick Mo

19. (a) 2-22-48 (b) Mrs R E Palmer
(Date received local registrar) (Registrar's signature)

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 Dr. L. L. ... (M. D. or other) _____
Address Ellis Fischel State Cancer Hosp. Columbia Mo. Date signed 2/22/48

RECEIVED
District Health Officer No. 9,
License File Number
Date Filled 3/12/48

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 *Victor E. Erminger*
Licensed Embalmer No. *2896*
P. O. Address *Liberty, 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.