

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **13215**  
Registrar's No. **48**

FILED APR 20 1948

Registration District No. **282**

Primary Registration District No. **5655**

1. PLACE OF DEATH:

(a) County **Lawrence**

(b) City or town **Mount Vernon**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
**Missouri State Sanatorium**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **629 days**  
(Specify whether years, months or days)

In this community **629 days**  
(years, months or days)

3. (a) PRINT FULL NAME **William Bailey**

3. (b) If veteran, name war **yes**

3. (c) Social Security No. \_\_\_\_\_

4. Sex **Male** 5. Color or race **White**

6. (a) Single, widowed, married; divorced **Married**

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **September 24 1893**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>54</b>	<b>6</b>	<b>25</b>	hr. _____ min.

9. Birthplace **Great Bend Kansas**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Construction**

11. Industry or business \_\_\_\_\_

12. Name **William Bailey**

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

14. Maiden name **Nettie Lawhorn**

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

16. (a) Informant **Ethel McMichael, Record Clerk**

(b) Address **Mo. State San, Mount Vernon, Mo.**

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Newton**

(c) City or town **Joplin**  
**Route # 4, Box 16**  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **18**  
year **1948** hour **5** minute **15 a.M.**

21. I hereby certify that I attended the deceased from **July 30**, 19 **46** to **April 18**, 19 **48**

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19 \_\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary tuberculosis** Duration **About 8 yrs**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

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 \_\_\_\_\_

23. Signature **P. O. Knasher** (M.D. or other) \_\_\_\_\_

Address **Mo. State San, Mount Vernon, Mo.** signed **4-18-48**

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

MOTHER FATHER

MAY 4 1944

MAY 3 1944

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..... *F M Jones*

Licensed Embalmer No. *2319*

P. O. Address..... *John 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. may  
Registrar's No. 48

Registration District No. 283 Primary Registration District No. 655

1. PLACE OF DEATH:  
(a) County Lawrence  
(b) City or town mt Vernon  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(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

3. (a) PRINT FULL NAME Wm Bailey  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_  
7. Birth date of deceased Sept 24 (Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

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

(c) Place: burial or cremation Osborne Memorial Center

18. (a) Signature of funeral director Parker, Hunsader

(b) Address Jefferson, Missouri

19. (a) April 19, 1944 (b) Cecil Hendricks (Registrar's signature) (c) MB (Date received local registrar)

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

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_  
that I last saw him \_\_\_\_\_ and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings:  
Of operations \_\_\_\_\_  
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 \_\_\_\_\_ (M. D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

S-13215