FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JUL 21 1948

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23604

Registration District No. 218 Primary Registration District No. 4330 Registrar's No. 41

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

1. PLACE OF DEATH:

(a) County Mississippi

(b) City or town (~~Rural~~) East Prairie
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Residence
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether In this community 10 years years, months or days)

2. USUAL RESIDENCE OF DECEASED: 67

(a) State Missouri (b) County Mississippi

(c) City or town (Rural) East Prairie
(If outside city or town limits, write "RURAL")

(d) Street No. 3 Miles South East Prairie, Mo.
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country ____

3. (a) PRINT FULL NAME JOSEPH MONROE BAILEY

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Div.

6. (b) Name of husband or wife Venie Bailey 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased March (Month) 11 (Day) 1887 (Year)

8. AGE: Years 61 Months 3 Days 17 If less than one day ____ hr. ____ min.

9. Birthplace Izard County (City, town, or county) Arkansas (State or foreign country)

10. Usual occupation Farmer

11. Industry or business ____

FATHER
12. Name unknown
13. Birthplace unknown (City, town, or county) Arkansas (State or foreign country)

MOTHER
14. Maiden name Annie Feller
15. Birthplace unknown (City, town, or county) Arkansas (State or foreign country)

16. (a) Informant Mrs Duncan Hale
(b) Address East Prairie, Mo. Rt. 1

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 30, 1948 (Month) (Day) (Year)
(c) Place: burial or cremation W.O.W. Cemetery

18. (a) Signature of funeral director Travis Shelby
(b) Address East Prairie, Mo.

19. (a) 7-9-48 (Date received local registrar) (b) Gertrude G. Harper (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 28 year 1948 hour 4 minute 30 A.M.

21. I hereby certify that I attended the deceased from Attended as Coroner, 19__; that I last saw him alive on ____, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion — Duration Few min.

Due to ____

Due to Had heart attacks but would not go to Doctor

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

Major findings:
Of operations ____
Of autopsy ____

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? ____ (Specify type of place)

While at work? ____ (e) Means of injury ____

23. Signature John F. Nunnelley (M. D. or other) Coroner

Address Charleston Mo Date signed 6/28/48

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No.
District File Number 248-8
Date Filed 7-19-

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 Travis Wade Shelby Jr., Registered Apprentice No. working under my personal supervision.

Signed Travis Shelby

Licensed Embalmer No. 2726

P. O. Address East Prairie, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Aug

Registration District No. 218 Primary Registration District No. 4830 Registrar's No. 41

1. PLACE OF DEATH:

(a) County Mississippi

(b) City or town East Prairie
(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)

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

3. (a) PRINT FULL NAME Joseph M. 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 divorced

6. (b) Name of husband or wife

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

7. Birth date of deceased March (Month) 11 (Day) 88 (Year)

8. AGE: Years 61 Months 3 Days 17 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

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

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 h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

5-23604