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MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **35832**

FILED NOV 30 1948
Registration District No. _____

Primary Registration District No. **3010**

Registrar's No. **370**

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

1. PLACE OF DEATH:

(a) County Cape

(b) City or town Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Frances Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 4 days
years, months or days

3. (a) PRINT FULL NAME COLEN ISABELL BAILEY

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife X

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

7. Birth date of deceased: November 11, 1881
(Month) (Day) (Year)

8. AGE: Years 67 Months 0 Days 8

If less than one day hr. _____ min. _____

9. Birthplace Unknown N. Carolina
(City, town, or county) (State or foreign country)

10. Usual occupation House-wife

11. Industry or business X

12. Name Silas Baxter Smith

13. Birthplace Unknown N. Carolina
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Brasswell

15. Birthplace Unknown N. Carolina
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Charlie Flowers

(b) Address Portageville, Mo.

17. (a) Removal (b) Date thereof: 11/19/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Henderson, Tenn.

18. (a) Signature of funeral director: H. S. Smith, Fun. Home

(b) Address Caruthersville, Mo.

19. (a) 11-24-48 (b) C. C. Summers
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pemiscot

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

(d) Street No. Rural Route 2
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 19,
year 1948 hour 4 minute 30 P. M.

21. I hereby certify that I attended the deceased from 11-11-48
_____ 19____ to 11-19 1948

that I last saw her alive on 11-18 1948
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Complete anuria</u>	<u>3 days</u>
Due to <u>Chronic interstitial nephritis</u>	
Due to _____	
Other conditions <u>Cholelithiasis with lithiasis and common duct stones</u>	<u>1 yr</u>

Major findings: Cholelithiasis with lithiasis and common duct stones

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature R. A. Pitter M.D. (M. D. or other) _____

Address Cape Girardeau Mo. Date signed 11-23-48

RECEIVED

District Health Officer No. 4

District File Number 1148-1142

Date Filed 11-29-48

DEC 30 1948

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. 4185

P. O. Address Parishville, Md.

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.