

FILED AUG 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH27597
State File No.

BIRTH NO. <u>350</u>		REG. DIST. NO. <u>274</u>		PRIMARY REG. DIST. NO. <u>3052</u>		Registrar's No. <u>273</u>	
1. PLACE OF DEATH a. COUNTY <u>Pettis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Benton</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>Sedalia</u>		c. LENGTH OF STAY (in this place) <u>8 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Warsaw</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Bothwell Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>Rural Route 3</u>			
3. NAME OF DECEASED (Type or Print) <u>Baby</u>		a. (First)		b. (Middle)		c. (Last) <u>BAILEY</u>	
4. DATE OF DEATH <u>Aug. 9, 1949</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>1</u>	
8. DATE OF BIRTH <u>Aug. 6, 1949</u>		9. AGE (In years last birthday) <u>0</u>		10. MONTHS <u>0</u>		11. DAYS <u>3</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>Sedalia, Missouri</u>	
13a. FATHER'S NAME <u>Harold E. Bailey</u>		13b. MOTHER'S MAIDEN NAME <u>Lora Grace Nichols</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Harold E. Bailey</u>		ADDRESS <u>Warsaw, Missouri</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Respiratory Paralysis</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Thrombosis</u> DUE TO (c) <u>Congenital Cystic Renal Degeneration</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Pyloric Stenosis, complete.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>69 hrs</u> <u>69 hrs</u> <u>69 hrs</u> <u>69 hrs</u>	
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>—</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>7571</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>—</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>8-6-</u> , 19 <u>49</u> , to <u>8-9-</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>8-9-</u> , 19 <u>49</u> , and that death occurred at <u>4:15 A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>J. M. Rodeman</u>		(Degree or title) <u>M.D.</u>		23b. ADDRESS <u>219 1/2 S. Ohio - Sedalia, Mo.</u>		23c. DATE SIGNED <u>8-9-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug. 10, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Riverside</u>		24d. LOCATION (City, town, or county) (State) <u>Warsaw, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>8-10-49</u>		REGISTRAR'S SIGNATURE <u>Betty Yeager Deputy</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Bean</u>		ADDRESS <u>Warsaw, Mo.</u>	

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

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED AUG 15

District Health Officer No. 8,

District File Number _____

Date Filed 8-19-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

John J. Riser

Signed _____
Student Embalmer

Licensed Embalmer No. 4098

P. O. Address Warsaw

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.