

FILED NOV 4 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH34299
State File No.

BIRTH NO. _____		REG. DIST. NO. <u>178</u>		PRIMARY REG. DIST. NO. <u>5662</u>		Registrar's No. <u>5</u>	
1. PLACE OF DEATH a. COUNTY <u>Lewis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Knox</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>La Belle TWP.</u>		c. LENGTH OF STAY (in this place) <u>1</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Colony</u>		<u>5</u> <u>0</u> <u>1</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Life</u>				d. STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>EMMA</u>		a. (First)		b. (Middle) <u>BAILEY</u>		c. (Last)	
4. DATE OF DEATH <u>Oct. 27 1949</u>		(Month) (Day) (Year)					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Dec. 26, 1829</u>	
9. AGE (In years last birthday) <u>69</u>		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>8</u>		11. IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Deeridge, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John W. Roberts</u>		13b. MOTHER'S MAIDEN NAME <u>Annie D. Stafford</u>		14. NAME OF HUSBAND OR WIFE <u>Charles Bailey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT'S SIGNATURE OR NAME <u>James B. Roberts</u>		ADDRESS <u>Wagonda, 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>Coronary Occlusion</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Sclerosis of Arteries</u> DUE TO (c) <u>Not Known</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>				INTERVAL BETWEEN ONSET AND DEATH <u>only</u> <u>flow print</u> <u>4201</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>None</u>				20. AUTOPSY? YES ☐ NO ☐	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. <u>---</u>		21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 20, 1949</u> , to <u>Oct. 26, 1949</u> , that I last saw the deceased alive on <u>Oct. 26, 1949</u> , and that death occurred at <u>4:15 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>H. Lillard, M.D.</u>				(Degree or title)		23b. ADDRESS <u>La Belle Mo</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10/28/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Bailey Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Near Colony, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>10-29-49</u>		REGISTRAR'S SIGNATURE <u>P. C. Jennings</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. L. Lillard, Jr.</u>		ADDRESS <u>La Belle, Mo.</u>	

(Licensed Embalmers' Statement on Reverse Side)

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

RECEIVED OCT 31 1949

District Health Officer No. 10

District File Number 10-49-18

Date Filed OCT 31 1949

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 _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Student Embalmer No. _____

Licensed Embalmer No. 4328

P. O. Address _____

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.