

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 22892

FILED AUG 14 1951

BIRTH NO. _____		REG. DIST. NO. <u>142</u>		PRIMARY REG. DIST. NO. <u>4231</u>		Registrar's No. <u>29</u>	
1. PLACE OF DEATH a. COUNTY <u>Howell</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Shannon</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>Mountain View</u>		c. LENGTH OF STAY (In this place) <u>1 min.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Winona,</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>None</u>				d. STREET ADDRESS (If rural, give location) <u>Rural</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Fred</u>		b. (Middle) <u>Joshua</u>		c. (Last) <u>Bailey</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 30-51</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Sept 25-1900</u>		9. AGE (In years last birthday) <u>50</u> If under 1 year: Months <u>9</u> Days <u>5</u> If under 12 hours: Hours <u>5</u> Mins. <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Dennison Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>William Bailey</u>		13b. MOTHER'S MAIDEN NAME <u>Amanda Walker</u>		14. NAME OF HUSBAND OR WIFE <u>Pauline Bailey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>347-07-8590</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Pauline Bailey Winona, Mo</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.  I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Broken Neck</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>8/10 26</u>				INTERVAL BETWEEN ONSET AND DEATH. <u>30 min</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Railway</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Mountain View Howell Mo</u>			
21d. TIME OF INJURY (Month) (Day) (Year) <u>July 30 1951</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Car struck on way to work</u>			
22. I hereby certify that I attended the deceased from <u>July 30, 1951</u> , to <u>July 30, 1951</u> , that I last saw the deceased alive on <u>July 30, 1951</u> , and that death occurred at <u>8:00</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>R. M. Mearns M.D.</u>		(Degree or title)		23b. ADDRESS <u>Mountain View Mo</u>		23c. DATE SIGNED <u>8-1-51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug 2 1951</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Summers Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Eminence, Mo</u>	
DATE REC'D BY LOCAL REG. <u>8-4-51</u>		REGISTRAR'S SIGNATURE <u>Laura M. Mearns</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Duncan Funeral Home Mtn View, Mo</u>		ADDRESS	

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10-48

460

DIVISION OF HEALTH OF MD.  
District No. 5 - Springfield

RECEIVED AUG 6 1951

Dist. File

Date Filed

851-1453

8-9-51

JUL 16 1951

### 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

Student Embalmer No. \_\_\_\_\_

Signed \_\_\_\_\_

Joe R. Duncan

Licensed Embalmer No. 4325

P. O. Address Mt. View 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.