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0.48

FILED JUL 26 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23420**

BIRTH NO. _____ REG. DIST. NO. **157** PRIMARY REG. DIST. NO. **3028** Registrar's No. **149**

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): a. STATE Missouri b. COUNTY Jasper	
b. CITY (If outside corporate limits, write RURAL and give township) Carthage		c. CITY (If outside corporate limits, write RURAL and give township) Carthage	
c. LENGTH OF STAY (in this place) 2 1/2 yrs		d. STREET ADDRESS (If rural, give location) 1035 S. Clinton St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1035 S. Clinton St.		e. CITY (If outside corporate limits, write RURAL and give township) 0493	

3. NAME OF DECEASED (Type or Print) a. (First) EDWARD b. (Middle) CARROLL c. (Last) BAILEY			4. DATE OF DEATH (Month) (Day) (Year) July 19, 1951			
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Aug 10, 1896	9. AGE (In years last birthday) 54	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired officer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Army		11. BIRTHPLACE (State or foreign country) Carthage, Missouri		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Ed Bailey	13b. MOTHER'S MAIDEN NAME Pearl Hodson	14. NAME OF HUSBAND OR WIFE Mabel S. Bailey
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give year or dates of service) World War I & II	16. SOCIAL SECURITY NO. 488-05-1186	17. INFORMANT'S SIGNATURE OR NAME Mrs. E. C. Bailey, 1035 Clinton, Carthage,
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion & infarction recurrent		immed.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 1st occlusion May 17, 1951 - 2 AM (anterior infarction left ventricle) DUE TO (c) Diag. by EKG - 15 hrs later		63 days
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4201	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **May 17, 1951**, to **July 19, 1951**, that I last saw the deceased alive on **July 2, 1951**, and that death occurred at **6:00 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE Emery J. Walters M.D. (Degree or title)	23b. ADDRESS Carthage, Mo.	23c. DATE SIGNED JUL 20 1951
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24a. BURIAL / CREMATION REMOVAL (Specify) Burial	24b. DATE July 23, 1951	24c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery	24d. LOCATION (City, town, or county) (State) Webb City, Missouri.
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DATE REC'D BY LOCAL REG. 7-21-51	REGISTRAR'S SIGNATURE L. B. Clenton, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Knell Mortuary ADDRESS Carthage, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

7-25-51

County Health Office

County File Number 51/7/594

Date Filed 7-25-51

RECEIVED
AUG 1 1951

AUG 2 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed Robert H. Knell

Licensed Embalmer No. 4459

P. O. Address Carthage

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.