

FILED MAR 12 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4017

State File No.

BIRTH NO. _____ REG. DIST. NO. 65 PRIMARY REG. DIST. NO. 4113 Registrar's No. 20

1. PLACE OF DEATH a. COUNTY <u>CHARITON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>CHARITON</u>	
b. CITY OR TOWN <u>BRUNSWICK</u>		c. CITY OR TOWN <u>BRUNSWICK TWP</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>LIFE</u>		e. STREET ADDRESS (If rural, give location) <u>14 MILE N. OF BRUNSWICK</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>104 MAIN ST</u>			
3. NAME OF DECEASED (Type or Print) <u>LAWRENCE T BAILEY</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>3-6-57</u>	
a. (First)		b. (Middle)	
c. (Last)			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>6-26-1904</u>
9. AGE (In years last birthday) <u>52</u>		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>POPPLEMISSOURI MISSOURI</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>DANIEL BAILEY</u>		13b. MOTHER'S MAIDEN NAME <u>ANNA</u>	14. NAME OF HUSBAND OR WIFE <u>ERNA BAILEY</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>512-01-9074</u>	17. INFORMANT'S SIGNATURE OR NAME <u>MRS. ERNA BAILEY</u> ADDRESS _____
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>D.A.A.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Short</u>	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>obesity</u>	
ANTECEDENT CAUSES		DUE TO (b) <u>Arteriosclerosis disease</u> <u>4 yrs</u>	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) <u>Coronary disease</u> <u>4 yrs</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4201</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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) <u>0</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-6-1957</u> to <u>3-6-</u> , 19 <u>57</u> that I last saw the deceased alive on _____, 19____, and that death occurred at <u>5:35</u> pm., from the causes and on the date stated above.			
23a. SIGNATURE <u>Traver C. Rice, M.D.</u> (Degree or title)		23b. ADDRESS <u>Branswick Mo</u>	
23c. DATE SIGNED <u>3-8-57</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>3-9-57</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Sumner Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>CHARITON Mo</u>	
DATE REC'D BY LOCAL REG. <u>3-9-57</u>		REGISTRAR'S SIGNATURE <u>Mildred Stone</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Lo McCurry</u>		ADDRESS <u>Brunswick, Mo</u>	

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

0210

Please name the deceased

56-0

The deceased was dead on arrival -
I am informed by deceased wife that he
had bouts of heart-attacks and has been
hospitalized and under treatment for heart
for 4 to 5 years (yrs). evidently he had vascular
Disease. Grover C. Rice M.D.

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
Signature of Student Embalmer

Signed *L. C. McLaughlin*
Licensed Embalmer No. *480*

P. O. Address *Princeton*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.