

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **12676**

FILED MAY - 9 1957

BIRTH NO. _____		REG. DIST. NO. <u>114</u>	PRIMARY REG. DIST. NO. <u>4486</u>	Registrar's No. <u>23</u>
1. PLACE OF DEATH a. COUNTY <b>Franklin</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Franklin</b>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Sullivan Mo.</b>		c. LENGTH OF STAY (If applicable) <b>life</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Sullivan Mo.</b>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)		
3. NAME OF DECEASED (Type or Print) a. (First) <b>Sarah</b>		b. (Middle) <b>Helms</b>		c. (Last) <b>Bailey</b>
4. DATE OF DEATH (Month) (Day) (Year) <b>May 4 1957</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>Sept. 27 1877</b>	9. AGE (In years last birthday) <b>79</b> 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) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Missouri</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>				
13a. FATHER'S NAME <b>John Helms</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah Helms</b>		14. NAME OF HUSBAND OR WIFE <b>Silas Bailey</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If you give war or dates of service) <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Evertt Bailey Sullivan Mo.</b>
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Thrombosis</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>arteriosclerotic Heart disease</b> DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs</b>  <b>5 yrs</b>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY <input type="checkbox"/> YES <input checked="" type="checkbox"/> 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) <b>4200</b>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		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>June, 1952</u> , to <u>May 5, 1957</u> , that I last saw the deceased alive on <u>May 5, 1957</u> , and that death occurred at <u>1:15 P.M.</u> , from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) <b>Ronald N. Scott, D.O.</b>		23b. ADDRESS <b>Sullivan Mo</b>		23c. DATE SIGNED <b>5/7/57</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		24b. DATE <b>May 7 1957</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Cave Spring</b>
24d. LOCATION (City, town, or county) (State) <b>Franklin County Mo.</b>				
DATE REC'D BY LOCAL REG <b>5/6/57</b>		REGISTRAR'S SIGNATURE <b>Thomas C. Humphrey</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Wm. P. Shaffer Sullivan Mo</b>

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

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MAY-10-1957

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 Pho. P. Shaffer

Licensed Embalmer No. 2692

P. O. Address Sullivan, Mo.

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.