

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-036957
STATE FILE NUMBER

FILED OCT 22 1958 Registration District No. 170 Primary Registration District No. Registrar's No. 144

S. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>LACLEDE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Camden</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ELDRIDGE TS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Climax Springs</u> 0150
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Cedar Grove Rest Home</u>		Length of stay in lb <u>2 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>None</u>
3. NAME OF DECEASED (Type or print) First Middle Last <u>BURREY - Bailey</u>			4. DATE OF DEATH Month Day Year <u>Oct 8 1958</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 3, 1877</u>
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>	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>81 4 5</u>
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11c. BIRTHPLACE (City and state or country) <u>North Carolina</u>
12a. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>		14. NAME OF HUSBAND OR WIFE <u>Lizzie Bailey</u>	
13a. FATHER'S NAME <u>Cornelius Bailey</u>		13b. MOTHER'S MARDEN NAME <u>Louada Deaton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give unit or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Lizzie Bailey</u>		Address <u>Climax Springs</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Paralytic Stroke</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 Days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cardiac Decompenstation</u>			<u>30 Min.</u>
DUE TO (c) <u>334X</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <u>Sept. 26, 1958</u> to <u>Oct. 8, 1958</u> and last saw her/him alive on <u>Oct. 8, 1958</u>		Death occurred at <u>2:20 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>W Bohrer</u> (Degree or title) <u>2</u>		22b. ADDRESS <u>D.O. 117 N. Jefferson, Lebanon,</u>	
22c. DATE SIGNED <u>10-9-58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Oct 9, 1958</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Climax Springs Cemetery</u>		23d. LOCATION (City, town, or county) <u>Climax Springs</u> (State) <u>Camden Co, Mo</u>	
24. FUNERAL DIRECTOR <u>John F. Peser</u>		ADDRESS <u>Warsaw Mo.</u>	
25. DATE RECD. BY LOCAL REG. <u>10-11-1958</u>		26. REGISTRAR'S SIGNATURE <u>Hella L. Hays</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

Received OCT 20 1958

Laclede County Health Unit

File No. 144

Date Filed OCT 20 1958

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 John J. Reser

Licensed Embalmer No. 4098

P. O. Address Warsaw

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.