Health, & Welfare Public Service
100
S. 300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-039657
STATE FILE NUMBER

FILED NOV 24 1958 Registration District No. 132 Primary Registration District No. ..... Registrar's No. 168

1. PLACE OF DEATH
a. COUNTY Grundy
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Galt — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) — Length of stay in lb 4 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo — b. COUNTY Grundy
c. CITY OR TOWN Galt — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First Middle Last: WILLIAM EPHRIAM BAILEY
4. DATE OF DEATH Month Day Year: 11-15-1958

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 6-6-1873
9. AGE (In years last birthday): 85 — 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 Farm
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Ky.
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: William Bailey
13b. MOTHER'S MAIDEN NAME: Sarah Ann Jones
14. NAME OF HUSBAND OR WIFE: Laura Boyers Bailey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: Mrs Laura Bailey Galt Mo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Hypostatic Pneumonia — 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Apoplexy — 1957 — 1 year
DUE TO (c) Malignant Hypertension — 8-10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 445X
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 July, to 1950 and last saw her/him alive on 11-15-58
Death occurred at 8:20 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): [signature] DO
22b. ADDRESS: Galt Missouri
22c. DATE SIGNED: 11/17/58

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 11-18-58
23c. NAME OF CEMETERY OR CREMATORY: Galt Mo
23d. LOCATION (City, town, or county) (State): Galt Mo

24. FUNERAL DIRECTOR ADDRESS: PK Payne Tour Galt Mo
25. DATE RECD. BY LOCAL REG.: 11-18-58
26. REGISTRAR'S SIGNATURE: Irene Tair

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 P K Payne Jr

Licensed Embalmer No. 3400

P. O. Address Galt

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.