

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010128
STATE FILING NUMBER

FILED MAR 19 1959

Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 42

11
300
1-57

1. PLACE OF DEATH a. COUNTY <u>MAEON</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>MAEON</u>		
b. CITY OR TOWN <u>MAEON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Bevick</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SAMARITAN</u>		Length of stay in 1b <u>1 week</u>	d. STREET ADDRESS (If outside, give location) <u>#1</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALLIE MAE BAILEY</u>			4. DATE OF DEATH Month Day Year <u>2-22-59</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-8-99</u>		9. AGE (In years last birthday) <u>60</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and state or country) <u>LUTTER, Tenn</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13a. FATHER'S NAME <u>George ALEXANDRIA</u>		13b. MOTHER'S MAIDEN NAME <u>Mrs. G. Troutt</u>		14. NAME OF HUSBAND OR WIFE <u>BERT J. 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>-</u>		17. INFORMANT <u>Bert J. Bailey</u> Address <u>Bevick Mo</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>Acute Intestinal Obstruction</u> DUE TO (b) <u>Metastatic Carcinoma of the Colon (Sigmoid)</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>5 Days</u> <u>8 months</u>
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 WORK <input type="checkbox"/> NOT WHILE 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>2-18-59</u> to <u>2/27/59</u> and last saw her alive on <u>2/27/59</u> Death occurred at <u>10:10 p</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>James E. Campbell M.D.</u>			22b. ADDRESS <u>Mo</u>		22c. DATE SIGNED <u>3/7/59</u>
23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) <u>Burial</u>		23b. DATE <u>3/2/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Richards, Elm</u>		23d. LOCATION (City, town, or county) (State) <u>Bevick Mo</u>
24. FUNERAL DIRECTOR <u>M.S. Edwards</u> ADDRESS <u>Bevick Mo</u>		25. DATE RECD. BY LOCAL REG. <u>3/11/59</u>		26. REGISTRAR'S SIGNATURE <u>Ruth Mcreeley</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.

OCT 14 1959

Date Filed 3/18/59

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 *H. Edwards* _____

Licensed Embalmer No. *196* _____

P. O. Address *Brown* _____

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.