

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013104

STATE FILE NUMBER

JUN 28 1959		Registration District No. 140		Primary Registration District No. 3024		Registrar's No. 35	
1. PLACE OF DEATH a. COUNTY Howard				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Howard			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fayette, Mo.				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Fayette 0451	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 312 S. Main St.				Length of stay in lb 6 yrs.		d. STREET ADDRESS (If outside, give location) 312 S. Main St.	
3. NAME OF DECEASED (Type or print) First RENA Middle MORRISON Last BAILEY				4. DATE OF DEATH Month Day Year APRIL 15, 1959			
5. SEX Female 1		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 19, 1869	
9. AGE (In years, months, days) 90		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		11. BIRTHPLACE (City and state or country) Howard County, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME James Pryor Morrison				13b. MOTHER'S MAIDEN NAME Caroline Stewart		14. NAME OF HUSBAND OR WIFE Warren Bailey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) No.				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Carolyn Miller 1239 Madison Ave New York 28	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia (Chronic Nephritis) DUE TO (b) Chronic Arteriosclerosis DUE TO (c) 446X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Senility (Psychosis) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
20e. CITY, TOWN, OR LOCATION Fayette, Mo.				20f. COUNTY STATE			
21. I attended the deceased from 1-1-59 to 4-15-59 and last saw her alive on 4-15-59 Death occurred at 8:10 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE M. D. Loom				22b. ADDRESS Fayette Mo		22c. DATE SIGNED 4-16-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/17/1959		23c. NAME OF CEMETERY OR CREMATORY City Cemetery		23d. LOCATION (City, town, or county) (State) Fayette, Missouri	
24. FUNERAL DIRECTOR Fayal A Carr				25. DATE RECD. BY LOCAL REG. 4-16-59		26. REGISTRAR'S SIGNATURE Mary L. Shell	

(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

MAY 18 1959

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, ~~only~~, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Ralph A. Carr*

Licensed Embalmer No. *3340*

P. O. Address *Jayette, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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