

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-020521  
STATE FILE NUMBER

FILED JUL 6 1959 Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 296

S. 300  
ev. 1-57

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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

1. PLACE OF DEATH a. COUNTY <b>Butler</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Stoddard</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Poplar Bluff</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Dexter</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Residence</b>		Length of stay in 1b	d. STREET ADDRESS <b>728 No. Mulberry</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Ellen</b> Last <b>Bailiff</b>			4. DATE OF DEATH Month <b>June</b> Day <b>22</b> , Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 7, 1891</b>	9. AGE (In years last birthday) <b>68</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>12</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School-teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Dudley, Missouri</b>	
10c. FATHER'S NAME <b>William Wilkerson</b>		13b. MOTHER'S MAIDEN NAME <b>Pamela Ann Dowdy</b>		14. NAME OF HUSBAND OR WIFE <b>W. D. Bailiff</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>W. D. Bailiff, Dexter, Missouri</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myelocytic Leukemia</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>2042</b>					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 _____ a.m. _____ p.m. Month, Day, Year _____					
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 <b>May 2, 1959</b> to <b>June 22, 59</b> and last saw her alive on <b>June 22, 1959</b> . Death occurred at <b>3:20 am</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>J. D. Rainey M.D.</i> (Degree or title)			22b. ADDRESS <b>Poplar Bluff, Mo.</b>		22c. DATE SIGNED <b>6-22-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>6-24-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dexter</b>		23d. LOCATION (City, town, or county) (State) <b>Dexter, Missouri</b>
24. FUNERAL DIRECTOR <b>Strickland-Rainey</b>		ADDRESS <b>Dexter, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>6/27/59</b>	26. REGISTRAR'S SIGNATURE <i>B. M. ...</i>

JUL 14 1961

FILE NO.

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 *Suzanne Rainey*.....

Licensed Embalmer No. *4983*....

P. O. Address.. *Alpharetta, Ga. 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.