RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS AUG 17 1959

59-029839
STATE FILE NUMBER

Registration District No. 227 Primary Registration District No. 5804 Registrar's No. 29

DED

1. PLACE OF DEATH
a. COUNTY: MONROE
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: JACKSON TWP.
Length of stay in 1b: 5 MONTHS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: PLESANT VIEW REST HOME
Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO
b. COUNTY: MONROE
c. CITY OR TOWN: SANTA FE
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): MAIN ST.
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: ISAAC Middle: NEWTON Last: BAILEY
4. DATE OF DEATH: Month: AUG. Day: 9 Year: 1959
5. SEX: M
6. COLOR OR RACE: W
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: SEPT. 13, 1868
9. AGE (last birthday): 91
IF UNDER 1 YEAR: Months: 10 Days: 24
IF UNDER 24 HR: Hours: — Min.: —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): GENERAL MERCHANT
10b. KIND OF BUSINESS OR INDUSTRY: RETAIL MERCHANT
11. BIRTHPLACE (City and state or country): MONROE, CO. MO.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: TILMAN BAILEY
13b. MOTHER'S MAIDEN NAME: SARAH ANN STALCUP
14. NAME OF HUSBAND OR WIFE: LONAH B. BAILEY
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: LONAH B. BAILEY Address: SANTA FE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: [illegible]
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) [illegible] — [illegible]
DUE TO (c) [illegible] — [illegible]
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

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 24, 59 to Aug 9-59 and last saw ~~him~~ alive on Aug 9-59
Death occurred at 8-9-59-11:[illegible] P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: [illegible] (Degree or title)
22b. ADDRESS: PARIS, MO.
22c. DATE SIGNED: 8/11/59

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 8/12/59
23c. NAME OF CEMETERY OR CREMATORY: SANTA FE CEMETERY
23d. LOCATION (City, town, or county) (State): SANTA FE, MO.

24. FUNERAL DIRECTOR: E.H. AGNEW ADDRESS: PARIS, MO.
25. DATE RECD. BY LOCAL REG.: 8-11-59
26. REGISTRAR'S SIGNATURE: J.A. Barnett M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed E. H. Agnew

Signature of Student Embalmer

Licensed Embalmer No. 4000

P. O. Address Paris, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com 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.