

## FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-015952

FILED VS APR 27 1960

Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 65

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Laclede</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Laclede</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Lebanon</b>			Length of stay in 1b <b>2 days</b>		c. CITY OR TOWN <b>Lebanon</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Louise G. Wallace Hospital</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <b>Rural Rt. #4</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Laura</b> Middle <b>Bailey</b> Last <b>Bailey</b>				4. DATE OF DEATH Month <b>April</b> Day <b>16</b> Year <b>1960</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>11-30-96</b>	9. AGE (last birthday) <b>63</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (City and state or country) <b>TENNESSEE</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>John Schuster</b>			13b. MOTHER'S MAIDEN NAME <b>- Baker</b>			14. NAME OF HUSBAND OR WIFE <b>Wm. H. Bailey, Sr.</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>Wm. H. Bailey, Jr., Lebanon, Mo.</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>CORONARY Thrombosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>	
Conditions, if any, which gave rise to above cause (a), stating the under- lying 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)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <b>None</b> <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>12/16/54</b> to <b>4/16/60</b> and last saw her <b>4/16/60</b> Death occurred at <b>4/16/60 9:30 A.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>George E. Fisher M.D.</b> (Degree or title)				22b. ADDRESS <b>Lebanon, Mo</b>		22c. DATE SIGNED <b>4/18/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>4-18-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lebanon,</b>		23d. LOCATION (City, town, or county) <b>Lebanon, Missouri</b> (State)		
24. FUNERAL DIRECTOR <b>J. E. Shaw</b> ADDRESS <b>Lebanon, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>4-18-1960</b>		26. REGISTRAR'S SIGNATURE <b>Hella L. Day</b>		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

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 \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Gene C. Hunter*

Licensed Embalmer No. 473

P. O. Address

*Spfld. Ma*

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