

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-010802

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

FILED APR 15 1963 61

Primary Registration District No. 4107 Registrar's No. 138

VS 300  
Rev. 4/59

1 0201

2 0930

3

4 0

5 2

6

7 1

8 0

9 614X

10

11

12 1-0

13 1-0

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|                                                                                                                                                                                                                                                                                                                          |                                                                                                           |                                                                                                                                                                      |                                                                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Cedar</u>                                                                                                                                                                                                                                                                              |                                                                                                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo</u> b. COUNTY <u>St. Clair</u>                               |                                                                                             |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>El Dorado Springs</u>                                                                                                                                                                                                                            |                                                                                                           | c. CITY OR TOWN <u>El Dorado Springs</u>                                                                                                                             |                                                                                             |
| Length of stay in 1b <u>5 Days</u>                                                                                                                                                                                                                                                                                       |                                                                                                           | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                                                    |                                                                                             |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Cedar Co. Memorial Hospital</u>                                                                                                                                                                                                        |                                                                                                           | d. STREET ADDRESS (If outside, give location)<br><u>Route 5</u>                                                                                                      |                                                                                             |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Ira</u> Middle <u>William</u> Last <u>Bailey</u>                                                                                                                                                                                                                         |                                                                                                           | 4. DATE OF DEATH<br>Month <u>Apr.</u> Day <u>8</u> Year <u>1963</u>                                                                                                  |                                                                                             |
| 5. SEX <u>M</u>                                                                                                                                                                                                                                                                                                          | 6. COLOR OR RACE <u>W</u>                                                                                 | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>          | 8. DATE OF BIRTH <u>Jan-23-1898</u>                                                         |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Farmer</u>                                                                                                                                                                                                             |                                                                                                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>Baldwin, Kans</u>                                                                                                               |                                                                                             |
| 13a. FATHER'S NAME <u>Ira A. Bailey</u>                                                                                                                                                                                                                                                                                  |                                                                                                           | 13b. MOTHER'S MAIDEN NAME <u>Mary Labaugh</u>                                                                                                                        |                                                                                             |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                                                                                                    |                                                                                                           | 16. SOCIAL SECURITY NO. <u>510-26-2799</u>                                                                                                                           |                                                                                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Generalized peritonitis</u><br>DUE TO (b) <u>Acute epididymitis</u><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |                                                                                                           | 17. INFORMANT <u>Mrs. Leona Stram</u><br>Address <u>5128 Merriam Dr., Shawnee, Miss.</u>                                                                             |                                                                                             |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |                                                                                             |
| 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<br>Hour _____ a.m. _____ p.m.<br>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 <u>April 3, 1963</u> to <u>April 8, 1963</u> and last saw him alive on <u>4/8/63</u>                                                                                                                                                                                                    |                                                                                                           | Death occurred at <u>7:15 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.                                                 |                                                                                             |
| 22a. SIGNATURE (Degree or title)<br><u>Robert L. Magee M.D.</u>                                                                                                                                                                                                                                                          |                                                                                                           | 22b. ADDRESS <u>1 Dorado Springs, Mo.</u> DATE SIGNED <u>4/11/63</u>                                                                                                 |                                                                                             |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                                                                                               | 23b. DATE <u>Apr-11-1963</u>                                                                              | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Lebeck Cemetery</u>                                                                                                         | 23d. LOCATION (City, town, or county) (State)<br><u>Approx. 2 mi. N. Cedar Springs, Mo.</u> |
| 24. FUNERAL DIRECTOR<br><u>Melvin L. Janssens</u>                                                                                                                                                                                                                                                                        | ADDRESS<br><u>El Dorado Springs, Mo.</u>                                                                  | 25. DATE RECEIVED BY LOCAL REG.<br><u>4-11-63</u>                                                                                                                    | 26. REGISTRAR'S SIGNATURE<br><u>Joe E. Humphreys</u>                                        |

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

**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

*Melvin L. Jensen*

Licensed Embalmer No.

*#529*

P. O. Address

*El Paso, Texas*

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.

*Permit obtained 4-11-63*