42

FEB 25 1935

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1040

1. PLACE OF DEATH
County Henry Registration District No. 347
Township West Fieldarees Primary Registration District No. 5490
City Clinton (No. ..... St. ..... Ward)
File No. .....
Registered No. 86

2. FULL NAME Cecelia Bayes
(a) Residence. No. Clinton Mo St., ... Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF —

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 25 1857

7. AGE: Years 80 | Months 3 | Days 22 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Dependent Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN) Jersey city
(STATE OR COUNTRY) New York

PARENTS

10. NAME OF FATHER Frederick Bayes
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Londonderry
(STATE OR COUNTRY) Ireland
12. MAIDEN NAME OF MOTHER Dyl
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Princeton
(STATE OR COUNTRY) New Jersey

14. INFORMANT Miss Mattie Snyder
(Address) Clinton, Mo.

15. FILED 2-2 1935 J. R. Houston REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1 — 17 1935

17. I HEREBY CERTIFY, That I attended deceased from 1-3 1935 to 1-17 1935; that I last saw h. alive on 1-16 1935 and that death occurred, on the date stated above, at 12:20 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Arterial Sclerosis
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Place of Death
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) J. R. Houston, M. D.
19 (Address) Clinton mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Englewood	1-19-1935
20. UNDERTAKER	ADDRESS
Fred Wilkerson	Clinton

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No.....

City..... (No..... ..... St. ..... Ward)

2. FULL NAME.....

(a) Residence. No..... St., ... Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT.....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from.....
....., 19....., to....., 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

..... (duration) .....yrs.....mos.....ds.

CONTRIBUTORY.....
(SECONDARY)

..... (duration) .....yrs.....mos.....ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed)..... ....., M. D.

....., 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.