DEPARTMENT OF COMMERCE
BUREAU OF THE [stamp: NOV 19 1940]

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 35434

Registration District No. 347
Primary Registration District No. 3018
Registrar's No.

1. PLACE OF DEATH:
(a) County Henry
(b) City or town Clinton (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Henry
(c) City or town Clinton (If outside city or town limits write "RURAL")
(d) Street No. 610 S orchard St (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME: SARAH ANN BAILEY
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Fem
5. Color or race White
6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife James
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb (Month) 16 (Day) 1856 (Year)
8. AGE: Years 84 Months 8 Days 6 If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation HOUSEWORK
11. Industry or business
FATHER 12. Name Wm Jordon
13. Birthplace (City, town or county) Mo (State or foreign country)
MOTHER 14. Maiden name Sadie Blackwell
15. Birthplace (City, town, or county) Mo (State or foreign country)
16. (a) Informant Wm Hart
(b) Address Clinton Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-23-40 (Month) (Day) (Year)
(c) Place: burial or cremation Fields Creek
18. (a) Signature of funeral director Consalus + Peck
(b) Address Clinton Mo
19. (a) Nov 1-1940 (Date received local registrar) (b) Dr. J. R. Hamilton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 22 year 1940 hour minute 12:30 P.M.
21. I hereby certify that I attended the deceased from Sept 1, 1940, to Oct 22, 1940; that I last saw her alive on Oct 22, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Eczema [illegible] E... acitis	6 Mo
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 212 (Specify type of place)
While at work? (e) Means of injury
23. Signature H. Dunker (M. D. or other) M.D.
Address Clinton Mo Date signed 10-22-40

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1-17-39 X21492

111B

RECEIVED
District Health Officer No. 7,
District File Number 11-40-1641
Date Filed 11-14-40

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 ....

...., Registered Apprentice No. ....

working under my personal supervision.

Signed J. E. Consalus

Licensed Embalmer No. 1891

P. O. Address ....

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 this body is not embalmed, above space should be left blank.

No. 2B
2-21-40
I X22659

ROWENA MOORE

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35-434

Registration District No. 347 Primary Registration District No. 3018 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Henry
(b) City or town Clinton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Sarah Ann Bailey
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)
8. AGE: Years 84 Months 8 Days 6 If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 22 year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.
Immediate cause of death Edema of lungs ascites
Due to Bronchial pneumonia — Duration 3 da
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy
1978

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature J. L. Walker (M. D. or other) M.D.
Address Clinton Mo Date signed 12-13-40