

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. **37015**

FILED NOV 22 1949

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **137** PRIMARY REG. DIST. NO. **2023** Registrar's No. **259**

1. PLACE OF DEATH a. COUNTY <b>Henry</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MO</b> b. COUNTY <b>Henry</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>CLINTON</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>CLINTON</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>CLINTON GENL HOSP</b>		d. STREET ADDRESS (If rural, give location) <b>115 E GRAND RIVER</b>	
3. NAME OF DECEASED a. (First) <b>DORA</b> b. (Middle) <b>Ann</b> c. (Last) <b>BAILEY</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Nov 17 1949</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Wid</b>	8. DATE OF BIRTH <b>6/27/1876</b>
9. AGE (in years last birthday) <b>73</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>SAM SNODGRASS</b>		13b. MOTHER'S MAIDEN NAME <b>SUSSIE DE COMBES</b>	14. NAME OF HUSBAND OR WIFE <b>James E Bailey</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Beulah Bailey Clinton MO</b>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Bronchopneumonia</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Cerebral hemorrhage</b>	
19a. DATE OF OPERATION <b>None</b>		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>no</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <b>Feb 27, 1948</b> , to <b>Nov. 17, 1949</b> , that I last saw the deceased alive on <b>Nov. 17, 1949</b> , and that death occurred at <b>12:15 P. M.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>S. B. Hughes, M.D.</b> (Degree or title)		23b. ADDRESS <b>Clinton, Mo</b>	
23c. DATE SIGNED <b>11/18/49</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>11/19/1949</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>SHAWNE MOUND</b>		24d. LOCATION (City, town, or county) (State) <b>Shawnee mound MO</b>	
DATE REC'D BY LOCAL REG. <b>Nov-18-49</b>		REGISTRAR'S SIGNATURE <b>Florence Adams</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Consoles</b>		ADDRESS <b>Clinton MO</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

42  
1  
2

RECEIVED

District Health Officer No. 7

District File Number J.O. 49-1384

Date Filed 11.21.49

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 \_\_\_\_\_

Student Embalmer

Signed

*J. E. Consalieu*

Licensed Embalmer No. 1891

P. O. Address Clinton, Mo.

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, fact should be so stated above.