OCT 2 2 1935

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

Do not use this space.

26678

1. PLACE OF DEATH
County Jackson
Township Raw
City R. C. Mo.
Registration District No. 399
Primary Registration District No. 1602
File No. 2405
Registered No.
(No. General Hosp. #2 St. 3rd Ward)

2. FULL NAME Laurine Bailey
(a) Residence, No. 917 Michigan 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 Female
4. COLOR OR RACE Colored
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) 6-19-1905
7. AGE YEARS 30 MONTHS 2 DAYS 10 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas

FATHER
13. NAME James Price
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky

MOTHER
15. MAIDEN NAME Eliza Green
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tex

17. INFORMANT (ADDRESS) G. Record Clerk General Hospital #2
18. BURIAL, CREMATION, OR REMOVAL
PLACE Westlawn DATE Sept 3, 1935
19. UNDERTAKER (ADDRESS) N. W. Thatcher 1520 N. 5th St.
20. FILED 9-3-1935 M. M. Crowe Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-29, 1935
22. I HEREBY CERTIFY, That I attended deceased from 8-2, 1935, to 8-29, 1935
I last saw her alive on 8-29, 1935. Death is said to have occurred on the date stated above, at 2:00 P.m.
The principal cause of death and related causes of importance were as follows:
Acute Pulmonary
Tuberculosis
Date of onset
Other contributory causes of importance:
with Cavitation
Name of operation Date of
What test confirmed diagnosis? Was there an autopsy? Yes
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury
24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) [illegible], M. D.
(Address) General Hosp. #2

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