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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 10 1944
Registration District No. 53

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41829**
Registrar's No. **414**

Primary Registration District No. **3010**

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

1. PLACE OF DEATH:
(a) County Cape Girardeau
(b) City or town Cape Girardeau
(c) Name of hospital or institution:
Southeast Mo. Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
In this community Don't Know (Specify whether years, months or days)

3. (a) PRINT FULL NAME Grant Bailey
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced 2
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased unk
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
Past 65 hr. min.

9. Birthplace unk 9
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business.....

12. Name unk

13. Birthplace unk 9
(City, town, or county) (State or foreign country)

14. Maiden name unk

15. Birthplace unk 9
(City, town, or county) (State or foreign country)

16. (a) Informant Social Security Commission

(b) Address Cape Girardeau, Mo.

17. (a) Burial (b) Date thereof 12-27-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fairmont Cemetery

18. (a) Signature of funeral director L. J. Haman

(b) Address Cape Girardeau, Mo.

19. (a) 12-30-43 (b) E. D. Phelps
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **16**
(a) State Missouri (b) County Cape Girardeau
(c) City or town Cape Girardeau
(If outside city or town limits, write "RURAL")
(d) Street No. Cahoon Building - Broadway
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 26th
year 1943 hour 1 minute P. M.

21. I hereby certify that I attended the deceased from Dec 21 1943 to Dec 26 1943
that I last saw him alive on Dec 25 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Labor Pneumonia

Due to.....

Due to.....

Other conditions 27 Hobbs
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy no

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?
While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature [Signature] (M. D. or other) **0**

Address [Signature] Date signed 12-29-43
no.

RECEIVED

District Health Officer No. 4

District File Number 144-318

Date Filed 1-7-44

S-41929

S-41929

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.....

Licensed Embalmer No.....

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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Jan.

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County *Cape Girardeau*
(b) City or town *Cape Girardeau*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
S. E. Mo. Hosp.?
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution *5 da.* (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME

Grant Bailey

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex *M*

5. Color of race *W*

6. (a) Single, widowed, married, divorced *Widowed*

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased *unk.*
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day _____ min.
Post - 65

9. Birthplace (City, town, or county) (State or foreign country) *unk.*

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name (City, town, or county) (State or foreign country)

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) *12-30-43* (Date received local registrar) (b) *H. W. Phelps* (Registrar's signature)

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Dec* - Day *26* year *1943* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

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?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

5-41829