

FILED SEP 7 1945 **STANDARD CERTIFICATE OF DEATH**

State File No. _____

Registration District No. 27

Primary Registration District No. 8088

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Bates
 (b) City or town Hudson
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Home
 (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) 6 1/2 yrs

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Bates
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME William Everett Bailey
 3. (b) If veteran, name war none
 3. (c) Social Security No. none

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced married
 6. (c) Age of husband or wife if alive 54 years (Day) 1881 (Year)

8. AGE: Years 64 Months 8 Days 21
 If less than one day _____ hr. _____ min.

9. Birthplace Bates Co Mo
 (City, town, or county) (State or foreign country)

10. Usual occupation Stock Buyer

11. Industry or business _____

12. Name Wright Bailey

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

14. Maiden name Frances Stephenson

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

16. (a) Informant Mollie Bailey

(b) Address Appleton City Mo

17. (a) Burial (b) Date thereof 17 9 1945
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Appleton City Cem

18. (a) Signature of funeral director Frank Lee

(b) Address Appleton City Mo

19. (a) Aug. 3, 1945 (b) Mrs. Wilbert Steiner
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month July day 28
 year 1945 hour 9 minute 30 a.m.
 21. I hereby certify that I attended the deceased from July 1
 1945 to July 28 1945
 that I last saw him alive on July 27 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Heart failure
Comp of atheroma with

Due to myocarditis to
liver.

Due to _____

Other conditions HTN
 (Include pregnancy within 3 months of death)

Major findings: Of operations pa of abd
with tuberculosis
 Of autopsy liver

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 W. L. Steiner (M. D. or other) MD
 Address Appleton City Date signed 7-28

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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

on the 28th day of July 1945, Registered Apprentice No. _____
working under my personal supervision.

Signed

Frank Lee

Licensed Embalmer No. *1099*

P. O. Address

Appl. City

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.