

DEPARTMENT OF COMMERCE · · · · THE STATE BOARD OF HEALTH OF MISSOURI  
BUREAU OF THE CENSUS  
STANDARD CERTIFICATE OF DEATH

State File No. **28060**

**FILED** SEP 10 1948  
299

Registration District No. 299 Primary Registration District No. 3056 Registrar's No. 276

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

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Randolph  
(c) City or town Moberly  
(If outside city or town limits, write "RURAL")  
(d) Street No. 506 Cleveland  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Nancy Kay Bailey  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Aug 2 day \_\_\_\_\_  
year 1946 hour 10:30 minute 7 M.  
21. I hereby certify that I attended the deceased from Aug 16  
1946 to Aug 20 1946  
that I last saw her alive on Aug 26 1946  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced S O  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years

Immediate cause of death Cardiac Collapse Duration 1 da  
Due to Injection in spine +  
arthritis due to birth defect  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

7. Birth date of deceased June 27<sup>th</sup> 1945  
(Month) (Day) (Year)  
8. AGE: Years \_\_\_\_\_ Months 1 Days 23  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Walter Bailey  
13. Birthplace Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Freda Harrison  
15. Birthplace Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Wally Bailey

(b) Address Moberly Mo

17. (a) Burial (b) Date thereof Aug 22<sup>nd</sup> 46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Moberly Mo

18. (a) Signature of funeral director Mahan and Son  
(b) Address Moberly Mo

19. (a) Aug 22-46 (b) Leah Harrison Law  
(Date received local registrar) (Registrar's signature)

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. C. Griffith (M. D. or other) \_\_\_\_\_  
Address Moberly Date signed 8-21-46

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

RECEIVED  
District Health Officer No. 10  
District File Number 9:46:1657  
Date Recd SEP 7 1946

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 Albert K. Mahan

Licensed Embalmer No. 1849

P. O. Address Moberly 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.