

No. 2
-12-45
5-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 14 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8374

Registration District No. 82

Primary Registration District No. 3017

Registrar's No. 45

1. PLACE OF DEATH:

(a) County COOPER

(b) City or town BOONVILLE
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ST. JOSEPH'S HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ONE DAY
(Specify whether years, months or days)

In this community LIFE
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County COOPER

(c) City or town BOONVILLE
(If outside city or town limits, write "RURAL")

(d) Street No. WATER ST.
(If rural, give location)

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

3. (a) PRINT FULL NAME ROBERT BAILEY

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 12th
year 1947 hour _____ minute 6 P. M.

4. Sex MALE 5. Color or race NEGRO

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife DOUG BAILEY

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

7. Birth date of deceased OCTOBER 3 - 1881
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 12th, 1947 to _____, 19____
that I last saw him alive on March 12, 1947
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>5</u>	<u>9</u>	hr. _____ min. _____

Immediate cause of death Ruptured aneurism of abdominal aorta
Due to Strangulated Hernia

9. Birthplace COOPER COUNTY MISSOURI
(City, town, or county) (State or foreign country)

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

10. Usual occupation LABORER

11. Industry or business DAY LABOR

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

MOTHER FATHER {
12. Name UNKNOWN
13. Birthplace _____
(City, town, or county) (State or foreign country)

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

16. (a) Informant ROSA BAILEY
(b) Address BOONVILLE, MO.

17. (a) BURIAL (b) Date thereof 3/15/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director STEGNER
(b) Address BOONVILLE, MO.

19. (a) 3-20-47 (b) [Signature]
(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)
(c) Means of injury _____

23. Signature [Signature] (M. D. or other) M.D.
Address Boonville, Mo Date signed 3/19/47

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

381

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 4-12-47.....

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.....

FRED HARRIS

Registered Apprentice No. **476**

working under my personal supervision.

Signed.....

James W. Stegner

Licensed Embalmer No. **3780**

P. O. Address **BOONVILLE, 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.