

No. 300
10-48

FILED AUG 17 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27017**

BIRTH NO.		REG. DIST. NO. 209	PRIMARY REG. DIST. NO. 5767	Registrar's No. 231
1. PLACE OF DEATH a. COUNTY Marion		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Marion		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural - South River	c. LENGTH OF STAY (in this place) 9 Yrs	c. CITY OR TOWN West Ely,	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION South River Township		e. STREET ADDRESS (If rural, give location) None		
3. NAME OF DECEASED (Type or Print) a. (First) Aletha b. (Middle) W. c. (Last) Baily		4. DATE OF DEATH (Month) (Day) (Year) 8 - 5 - 1955		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan 16, 1893	9. AGE (In years last birthday) 62
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Peoria, Ill.	12. CITIZEN OF WHAT COUNTRY? US
13a. FATHER'S NAME John Hoston Wright		13b. MOTHER'S MAIDEN NAME Eliza Lane	14. NAME OF HUSBAND OR WIFE Clifford V. Baily	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) No		16. SOCIAL SECURITY NO. -----	17. INFORMANT'S SIGNATURE OR NAME Clifford V. Baily ADDRESS West Ely, Mo.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of descend. Colon DUE TO (c) 153X		INTERVAL BETWEEN ONSET AND DEATH 6 mo 1 yr
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 8/2 , 19 55 , to 8/5 , 19 55 , that I last saw the deceased alive on 8/2 , 19 55 and that death occurred at 4:00A m., from the causes and on the date stated above.				
23a. SIGNATURE [Signature] (Degree or title)		23b. ADDRESS Palmyra Mo.		23c. DATE SIGNED 8/8/55
24a. BURIAL CREMATION REMOVAL (Specify) Burial	24b. DATE 8-8-55	24c. NAME OF CEMETERY OR CREMATORY Grand View Burial Park	24d. LOCATION (City, town, or county) (State) Hannibal, Mo.	
DATE REC'D BY LOCAL REG. 8/9/55	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS Hannibal, Mo.		

(Licensed Embalmer's Statement on Reverse Side)

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

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RECEIVED AUG 16 1955
MARION CO. HEALTH DEPT.
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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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... 

Licensed Embalmer No. 4217

P. O. Address Hannibal, M.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.