URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS AUG 1 0 1960

-60-027956

STATE FILE NUMBER

ENDED

Registration District No. 390 Primary Registration District No. 4442 Registrar's No.

1. PLACE OF DEATH
a. COUNTY Randolph
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Higbee Mo
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION At Home
Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Randolph
c. CITY OR TOWN Higbee Mo
Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location)
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Micheal Middle: Wayne Last: Bailey

4. DATE OF DEATH Month: July Day: 29 Year: 1960

5. SEX Male

6. COLOR OR RACE White

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH I*17-1960

9. AGE (last birthday)

IF UNDER 1 YEAR Months 6 Days 12 IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (City and state or country) Meberly Mo

12. CITIZEN OF WHAT COUNTRY U. S. A.

13a. FATHER'S NAME John Bailey

13b. MOTHER'S MAIDEN NAME Bonnie Woods

14. NAME OF HUSBAND OR WIFE None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs Bonnie Bailey Address Higbee Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Hypostatic pneumonia	1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Hydrocephalus	5 mo
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 5-15-60, to 7-29-60 and last saw ~~him~~ him alive on 7-29-60

Death occurred at 11:20 PM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) W. H. McCormick O.D.

22b. ADDRESS Moberly Mo.

22c. DATE SIGNED 7-30-60

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE July 31 1960

23c. NAME OF CEMETERY OR CREMATORY City

23d. LOCATION (City, town, or county) (State) Higbee Mo

24. FUNERAL DIRECTOR Burton Funeral Home. ADDRESS Higbee Mo

25. DATE RECD. BY LOCAL REG. 7-30-1960

26. REGISTRAR'S SIGNATURE Joe W Burton

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision. Not Embalmed

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp 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.