

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

31538  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
(b) Township Kearney Primary Registration District No. 1002  
(c) City Kearney (d) Street No. Kearney Hosp Registered No. 121  
(e) Length of residence in city or town where death occurred yrs. mos. ds. 6 How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Bailey Infant  
(a) Residence, No. 2719 J road St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-12-38  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
Steelrith  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) KC Mo

FATHER 13. NAME John Bailey

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Grace

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) Record Clerk H.C. You Hospital

18. BURIAL, CREMATION OR REMOVAL PLACE DATE Keene Cem 9-14-38

19. FUNERAL DIRECTOR (ADDRESS) Walter B. Hapler 236 Campbell St

20. FILED Sept 13 1938 M. M. Cronin Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-12-38

22. I HEREBY CERTIFY, That I attended deceased from 9-12-38 to 9-12-38

I last saw him alive Steelrith, 19..... Death is said

to have occurred on the date stated above, at 1:00 p.m.

The principal cause of death and related causes of importance were as follows:

Steelrith Date of onset

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? Date of injury, 19.....

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) P. D. De Maria M. D.

(Address) Supt. K.C. Gen. Hosp

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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 .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

215-38  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
 (b) Township J.C. Primary Registration District No. 1002 Registered No. 121  
 (c) City J.C. (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Bailey Infant

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) s

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) Kansas City (STATE OR COUNTRY) Mo

FATHER 13. NAME John Bailey

14. BIRTHPLACE (CITY OR TOWN) Mo (STATE OR COUNTRY) Mo

MOTHER 15. MAIDEN NAME Grace Pearson

16. BIRTHPLACE (CITY OR TOWN) Stark (STATE OR COUNTRY) Mo

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED 9/18 38 M. M. Crowe Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-12 1938

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_

I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

stillbirth  
 Date of onset \_\_\_\_\_  
 Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_ (Signed) P. J. Demarcan, M. D.  
 Address Dept. H. C. New Hosp.  
J. C. New

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Exact statement of OCCUPATION is very important.

