DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17411

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 1938

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: 5416 E. 54th st. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community 44 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 5416 E 54th (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Florence D. Bailey BORENE D BAILEY

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Female

5. Color or race Negro

6. (a) ~~Single~~, widowed, ~~married~~, ~~divorced~~ Widow

6. (b) Name of husband or wife Frank Bailey

6. (c) Age of husband or wife if alive no years

7. Birth date of deceased June 13 1895 (Month) (Day) (Year)

8. AGE: Years 44 Months 10 Days 25 If less than one day x hr. x min.

9. Birthplace Springfield Mo (City, town, or county) (State or foreign country)

10. Usual occupation Maid

11. Industry or business None

FATHER
12. Name P. J. Koker
13. Birthplace Springfield Mo (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Kittie Whitte
15. Birthplace Springfield Mo (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Kittie Koker

(b) Address 5416 E. 54th st.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/11/40 (Month) (Day) (Year)

(c) Place: burial or cremation Blue Ridge Cemetery

18. (a) Signature of funeral director Ideal Fun. Home

(b) Address 1409 E. 12th st.

19. (a) May 9, 1940 (Date received local registrar) (b) W. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5-6-40

year ____ hour ____ minute 6 P M.

21. I hereby certify that I attended the deceased from ____, 19__ to ____, 19__; that I last saw he alive on ____, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death Perforate & Rectum Fecal Fistula

Due to Lymphopathia Venereum

Due to

Other conditions (Include pregnancy within 3 months of death) 34

Major findings: Of operations

Of autopsy abort

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Russell W Kerr (M. D. or other)

Address Kerr Date signed

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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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 wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.