

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15765
Registrar's No. 2245

FILED JUN 4 1945
Registration District No. 749

Primary Registration District No. 1002

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

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: Research Hospital B
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 weeks
(Specify whether in)

In this community 6 wks.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clay 211

(c) City or town Holt, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

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

3. (a) PRINT FULL NAME JAY FITCH BAILEY

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife Laura Belle Bailey

6. (c) Age of husband or wife if alive 84 years

7. Birth date of deceased June 26 1870
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>74</u>	<u>10</u>	<u>27</u>	hr. _____ min. _____

9. Birthplace New York State
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business _____

MOTHER FATHER

12. Name Jay Bailey

13. Birthplace New York State
(City, town, or county) (State or foreign country)

14. Maiden name Zoan Fitch

15. Birthplace New York State
(City, town, or county) (State or foreign country)

16. (a) Informant Beatrice Bailey

(b) Address 1010 E. 27th Kansas City Mo

17. (a) Burial (b) Date thereof May 24 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation not no

18. (a) Signature of funeral director Mrs. C. R. Foster

(b) Address 918 Brooklyn

19. (a) 5-29-45 (b) Stoddardine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 23
year 1945 hour 11 minute 20 PM.

21. I hereby certify that I attended the deceased from June, 1944, to May 23, 1945
and that I last saw him alive on May 23, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Arteriosclerosis (heart)

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 52 lb

Major findings: Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(c) 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)

(e) Means of injury 0

23. Signature Wm. W. Henderson (M. D. or _____)
Address Liberty, Mo Date signed 5/23/45

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.....

Carthaus J. Nison

Licensed Embalmer No. *3414*

P. O. Address: *918 Brooklyn*

Kansas City
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.