V. S. No. 2
00M—5-43
ev. 5-17-39
Form I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27005

FILED AUG 19 1946

Registration District No. 149 — Primary Registration District No. 1002 — Registrar's No. 3313

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Kansas City (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ~~[illegible]~~ Major Clinic (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 1 week (Specify whether years, months or days)
In this community: One week

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Atchison
(c) City or town: Rock port Mo (If outside city or town limits, write "RURAL")
(d) Street No.: 0 (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: John Motier Bailey
3. (b) Veteran: name war: no
3. (c) Social Security No.: none
4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: Widower
6. (b) Name of husband or wife: Una H. Bailey
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: April (Month) 9 (Day) 1859 (Year)

8. AGE: Years 87 | Months 3 | Days 22 | If less than one day: hr. min.
9. Birthplace: Gray Co (City, town, or county) Tenn (State or foreign country)
10. Usual occupation: Farmer
11. Industry or business:
FATHER 12. Name: Marion Bailey
13. Birthplace: (City, town, or county) Tenn (State or foreign country)
MOTHER 14. Maiden name: unknown
15. Birthplace: (City, town, or county) Tenn (State or foreign country)
16. (a) Informant: Donald M. Bailey
(b) Address: Rock port Mo
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 8-1-46 (Month) (Day) (Year)
(c) Place: burial or cremation: Rock port Mo
18. (a) Signature of funeral director: Mrs E. L. Fowler
(b) Address: KC Mo
19. (a) 8-1-46 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Aug day: 1st year: 1946 hour: 12 minute: 15 a.m.
21. I hereby certify that I attended the deceased from July 23rd 1946, 19..., to Aug 1st 1946, 19..., that I last saw him alive on July 31st 1946, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary occlusion	Sudden
Due to: Cerebral Thrombosis	2 wks
Due to: Senility & Cerebral arterioscleroses	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations: —
Of autopsy: — 94a

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: Hermon S. Mayer (M. D. or other)
Address: 3100 Euclid ave Kansas City 3 Mo Date signed: 8/1/46

(Licensed Embalmer's Statement on Reverse Side)

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

25827

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 G. H. Wise

Licensed Embalmer No. 25-70

P. O. Address KC. 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.