S. No. 2
I—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41567

FILED JAN 2 1947

Registration District No. 49

Primary Registration District No. 1002

Registrar's No. 5289

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

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

(d) Length of stay: In hospital or institution: 12 hours (Specify whether In this community years, months or days): Life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson 48

(c) City or town: Kansas City (If outside city or town limits, write "RURAL") 3

(d) Street No.: 7008 Bales Avenue (If rural, give location) 8

(e) Citizen of foreign country? no (Yes or No)

If yes, name country:

3. (a) PRINT FULL NAME: LeRoy BAILEY

3. (b) If veteran, name war: no

3. (c) Social Security No.: 486-09-2506

4. Sex: male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Retta Bailey

6. (c) Age of husband or wife if alive: 36 years

7. Birth date of deceased: March (Month) 1 (Day) 1908 (Year)

8. AGE: Years	Months	Days	If less than one day
39	9	~~18~~ 11	xx hr. xx min.

9. Birthplace: Kansas City (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: Filterman

11. Industry or business: Corn Products Inc.

FATHER
12. Name: Orval Bailey
13. Birthplace: Unknown (City, town, or county) (State or foreign country) 9

MOTHER
14. Maiden name: Anna Uhlig
15. Birthplace: Unknown (City, town, or county) (State or foreign country) 9

16. (a) Informant: Mrs Retta Bailey

(b) Address: 7008 Bales Kansas City Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 12-13-47 (Month) (Day) (Year)

(c) Place: burial or cremation: Greenlawn Cem. K.C. Mo.

18. (a) Signature of funeral director: Morton-Smith's F.H.

(b) Address: 832 Armour Rd. North Kansas City

19. (a) 12-16-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 12 year 1947 hour minute M.

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

Immediate cause of death: Shock

Due to: Skull Fracture

Due to: Injury By Fall fell from a tank car (n.m.o.)

Other conditions (Include pregnancy within 3 months of death): Deputy Coroner

Major findings:
Of operations: 1864
Of autopsy: See Above

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

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

(a) Accident, suicide, or homicide (specify): Accident 24

(b) Date of occurrence: 12-12-47

(c) Where did injury occur? No. K.C. Clay (City or town) (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? Yes (e) Means of injury: Trauma

23. Signature: A. E. Usher (M. D. or other) M.D.

Address: 2800 Main Date signed: 12/13/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 Chester L. Flaury, Registered Apprentice No. 447, working under my personal supervision.

Signed: Theron O. Smith

Licensed Embalmer No. 3928

P. O. Address North Kansas City, M

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.