

FILED DEC 5 - 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER  
40187  
5364

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

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Jackson</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Kansas City</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Kansas City</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St. Joseph Hospital</i>		Length of stay in 1b <i>34 YEARS</i>	d. STREET ADDRESS (If outside, give location) <i>205 East 65<sup>th</sup></i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>ARTHUR TOWNSEND BAILEY</i>			4. DATE OF DEATH Month Day Year <i>Nov. 12 1957</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan-6, 1882</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>office</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Joseph Dodge Inc. Lost Valley Long Island</i>	11. BIRTHPLACE (City and state or country) <i>N.Y.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13a. FATHER'S NAME <i>Fred Bailey</i>	
13b. MOTHER'S MAIDEN NAME <i>JENNIE DAVIS</i>		14. NAME OF HUSBAND OR WIFE <i>Lillian V. Bailey</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>500-22-2767</i>	17. INFORMANT <i>Lillian Bailey</i> Address <i>205 E. 65<sup>th</sup> St. K.C., Mo.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho-pneumonia</i>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Carcinoma of thyroid</i>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <i>1947</i>
DUE TO (c) <i>with multiple diffuse metastases</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <i>10-19-57</i> to <i>11-12-57</i> and last saw her alive on <i>11-11-57</i> Death occurred at <i>11:30 P.M.</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Vincent T. Williams</i> (Degree or title) <i>D</i>		22b. ADDRESS <i>836 Maple St.</i>	
		22c. DATE SIGNED <i>Nov 13 1957</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>Nov. 14-1957</i>	23c. NAME OF CEMETERY OR CREMATORY <i>FOREST HILL CEMETERY</i>	23d. LOCATION (City, town, or county) (State) <i>KANSAS CITY MISSOURI</i>
24. FUNERAL DIRECTOR <i>D.W. NEWCOMER'S SONS</i>		ADDRESS <i>331 Bush Creek K.C., Mo.</i>	25. DATE RECD. BY LOCAL REG. <i>11-14-57</i>
		26. REGISTRAR'S SIGNATURE <i>Reva Trindall</i>	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

Vincent T. Williams  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION



212-8581

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....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Bern Lawler* .....

Licensed Embalmer No. *4915*  
P. O. Address *47 E 32nd St* .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.