

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-006135

FILED VS MAR 3 1960

149

Registration District No.

Primary Registration District No. 1002

Registrar's No.

869

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jackson			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in lb 28 yrs.		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION General Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 827 Pennsylvania		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLARENCE Middle AMOS Last BAILEY				4. DATE OF DEATH Month 2 Day 12 Year 60			
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 12-9-82	9. AGE (last birthday) 77	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Apt. House Owner		10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (City and state or country) Russell County, Kansas		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Amos Bailey			13b. MOTHER'S MAIDEN NAME Alma Lindsey		14. NAME OF HUSBAND OR WIFE Sarah Bailey		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 500-03-8311	17. INFORMANT Address K.C., MO. Mr. Clarence E. Bailey; 2606 Rocheste				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bunch pneumonia						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Fracture of zygomatic arch of right					
		DUE TO (c) Comminuted fracture of frontal bone skull					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) Fell down stairs				
20c. TIME OF INJURY Hour 1 Month, Day, Year 27-60 a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		20f. CITY, TOWN, OR LOCATION Kansas City		COUNTY Jackson STATE MO
21. I attended the deceased from _____ to _____ and last saw him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Geo. C. Keel, M.D.				22b. ADDRESS 6027 Prospect St. Amos		22c. DATE SIGNED 2-10-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-16-60	23c. NAME OF CEMETERY OR CREMATORY Mount Washington Cem.		23d. LOCATION (City, town, or county) (State) Kansas City, Missouri		
24. FUNERAL DIRECTOR WEILERT FUNERAL HOMES (W)			ADDRESS K.C., MO.		25. DATE RECD. BY LOCAL REG. 2-13-60	26. REGISTRAR'S SIGNATURE Neva Minshall	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Geo. C. Keel, M.D.

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

B. E. Weibert

Licensed Embalmer No.

4075

P. O. Address

2 E 8, Ma

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.