ISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-029038
STATE FILE NUMBER

AMENDED

Registration District No. 139 Primary Registration District No. _____ Registrar's No. 50

FILED SEP 5 1961

1. PLACE OF DEATH
a. COUNTY HOLT
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN LEWIS TWP. — Length of stay in 1b 9 Yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION — Inside Limits Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO. b. COUNTY HOLT
c. CITY OR TOWN OREGON — Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) 1 Mi. North — Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First BRAD Middle ROBERT Last BAILEY
4. DATE OF DEATH Month AUG Day 21 Year 1961

5. SEX MALE
6. COLOR OR RACE WHITE
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 12/26/51
9. AGE (last birthday) 9 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) ST. JOSEPH MO.
12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME ROBERT REED BAILEY
13b. MOTHER'S MAIDEN NAME BONITA STELLA MERTENS
14. NAME OF HUSBAND OR WIFE NONE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT ROBERT REED BAILEY — Address OREGON, MO.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SUFFOCATION in grain BIN. — INTERVAL BETWEEN ONSET AND DEATH 2-5 MIN.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____
DUE TO (c) _____
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☒ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Playing in corn BIN-Drawn into it.
20c. TIME OF INJURY 5 Hour a.m. p.m. Month, Day, Year Aug 21, 61
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Farm 1 Mi. N. Oregon
20f. CITY, TOWN, OR LOCATION — COUNTY — STATE Mo.

21. I attended the deceased from ——, to —— and last saw her/him alive on ——.
Death occurred at 5 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) H. E. Calkin, D.O. Coroner
22b. ADDRESS OREGON, MO.
22c. DATE SIGNED 8/22/61

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE 8/24/61
23c. NAME OF CEMETERY OR CREMATORY OREGON
23d. LOCATION (City, town, or county) OREGON (State) MO.

24. FUNERAL DIRECTOR James H. Pettijohn — ADDRESS OREGON MO.
25. DATE RECD. BY LOCAL REG. 9/2/1961
26. REGISTRAR'S SIGNATURE James H. Crawford

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS: ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED | BY AFFIDAVIT OF | DOCUMENT

MEDICAL CERTIFICATION

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 James H Pettijohn

Licensed Embalmer No. 3192

P. O. Address Oregon 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.