

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-022861
2999 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

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

FILED JUN 25 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give-TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
Length of stay in 1b 13 YRS.		Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 4222 The Paseo		d. STREET ADDRESS (If outside, give location) 4222 The Paseo	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First FRENDIE Middle MAY Last BAYLES			4. DATE OF DEATH Month June Day 6 Year 1962		
5. SEX Female	6. COLOR OR RACE Cauc.	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/3/1868	9. AGE (last birthday) 93 95	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (City and state or country) Van Buren Co., Mich.	12. CITIZEN OF WHAT COUNTRY U.S.A.	

13a. FATHER'S NAME Charles Baker		13b. MOTHER'S MAIDEN NAME Sarah Jane Gould		14. NAME OF HUSBAND OR WIFE Frank C. Bayles	
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. None		17. INFORMANT Mrs. Cordia J. Smith, Kansas City, Mo.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a)		Gastric obstruction		1 day
DUE TO (b)		Pyloric spasm		1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (c)	1 yr	
Chronic colitis 1 yr.		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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 _____ a.m. _____ p.m.		Month _____ Day _____ Year _____			

20d. INJURY OCCURRED WHILE AT WORK <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	
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21. I attended the deceased from 1960 to 6-5-62 and last saw her live on 6-5-62
Death occurred at 12.5.0 a. m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Leo A. O'Brien M.D.		22b. ADDRESS 306 E 12 K-C 6M0		22c. DATE SIGNED 6-6-62	
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE June 6, 1962		23c. NAME OF CEMETERY OR CREMATORY Chillicothe, Missouri	
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24. FUNERAL DIRECTOR D.W. Newcomer's Sons, Kansas City, Mo.		25. DATE RECD. BY LOCAL REG. 6-6-62		26. REGISTRAR'S SIGNATURE Ruth H Long	
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USE BLACK INK OR TYPEWRITER RIBBON

MEDICAL CERTIFICATION

BY AFFIDAVIT OF **Leo A. O'Brien**

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 Thomas W. Corso

Licensed Embalmer No. 4889

P. O. Address Lathrop, 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.