

S. No. 2
M-5-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29532

State File No. _____

FILED SEP 20 1945
Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3726

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:
9 th and Mulberry St. /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None (Specify whether
years, months or days) 20 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

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

(d) Street No. 2759 East 27 th, Street 8
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 1

If yes, name country _____

3. (a) PRINT FULL NAME CLYDE O. BAILEY

(b) If veteran, name war No.

(c) Social Security No. 486-03-1943

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 5 th
year 1945 hour 10 minute 40 P.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Adaline Bailey 6. (c) Age of husband or wife if alive 36 years

7. Birth date of deceased August 25 th, 1908
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

CORONER

that I last saw h_____ alive on _____, 19____; and that death occurred on the date and hour stated above.

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|-----------|----------------------|
| | <u>37</u> | <u>0</u> | <u>10</u> | _____ hr. _____ min. |

Immediate cause of death Coronary Sclerosis

Due to Arterio Sclerosis

9. Birthplace Unknown Mo. 1
(City, town, or county) (State or foreign country)

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

10. Usual occupation Lay Out Man

11. Industry or business Pratt-Whitney

Major findings:
Of operations Stomach contents sent to laboratory
Of autopsy as above

MOTHER FATHER { 12. Name John M. Bailey

{ 13. Birthplace Unknown Indiana 1
(City, town, or county) (State or foreign country)

{ 14. Maiden name Grace Winder

{ 15. Birthplace Unknown Indiana 1
(City, town, or county) (State or foreign country)

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

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

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

16. (a) Informant Mrs. Adaline Bailey

(b) Address 2759 East 27 th, St. K.C. 1

17. (a) Burial (b) Date thereof 19-7-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery

While at work? _____ (Specify type of place) _____ (c) Means of injury _____

23. Signature J. M. Holmes (M. D. or other) _____
Address 444 W. Main St. Date signed 7-6-45

18. (a) Signature of funeral director Melody-McGille-Eylor

(b) Address 1800 Linwood Blvd. K.C. Mo.

19. (a) 7-8-45 (b) J. M. Holmes
(Date received local registrar) (Registrar's signature)

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

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

J. P. [Signature]
- Licensed Embalmer No. *2997 RC*
P. O. Address.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3726

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

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Manassas city
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
9th - + Mulberry
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
 (Specify whether
 In this community.....
 years, months or days)

3. (a) PRINT FULL NAME Clyde O. Bailey

3. (b) If veteran, name war..... 3. (c) Social Security No.

4. Sex..... 5. Color or race..... 6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year.....

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day hr. min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name..... (City, town, or county) (State or foreign country)

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 9-8-45 (b) Geraldine Holmes (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
 (c) City or town..... (If outside city or town limits write "RURAL.")
 (d) Street No..... (If rural, give location)
 (e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 5 year 1945 hour 10 minute 40 M.

21. I hereby certify that I attended the deceased from.....
Coroner..... 19.....

that I last saw h..... alive on..... 19.....
 and that death occurred on the date and hour stated above.

Immediate cause of death.....

Coronary sclerosis
arteriosclerosis
 Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

Major findings: stomach contents sent to laboratory - no poison
 Of autopsy yes, as above
 Underline the cause to which death should be charged statistically.

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

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?..... (City or town) (County) (State)

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

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature James C Walker (M. D. or other).....

Address 1424 Prof. Bldg Date signed 9-6-45

SUPPLEMENTARY

1945
S-29532