

FILED JAN 24 1946  
Registration District No. 177

Primary Registration District No. 1002

State File No. \_\_\_\_\_  
Registrar's No. 5479

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:  
709 Washington  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community unknown  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson <sup>48</sup>  
(c) City or town Kansas City, MO <sup>3</sup>  
(If outside city or town limits, write "RURAL")  
(d) Street No. 709 Washington <sup>8</sup>  
(If rural, give location) <sup>0</sup>  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Sam Bailey

3. (b) If veteran, name war none  
3. (c) Social Security No. Do not know

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 27  
year 1945 hour 10 minute 50 A M.  
21. I hereby certify that I attended the deceased from Resurrection, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or White  
6. (a) Single, widowed, married, divorced unm  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years  
7. Birth date of deceased unknown  
(Month) (Day) (Year)

Immediate cause of death Pericardial thrombosis  
Due to arterio-sclerosis  
Due to \_\_\_\_\_

8. AGE: Years 70 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: 83w  
Of operations \_\_\_\_\_

9. Birthplace Do not know (City, town, or county) \_\_\_\_\_ (State or foreign country) A

10. Usual occupation none

11. Industry or business \_\_\_\_\_

12. Name Do not know

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

14. Maiden name Do not know

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

16. (a) Informant Cerian officer

(b) Address 12 C 700

17. (a) School (b) Date thereof Jan 3 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial, cremation, or removal College of Our Lady & St. August

18. (a) Signature of funeral director Geraldine Holmes

(b) Address 12 C 700

19. (a) 12-31-45 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

Of autopsy no  
Histology & inspection

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 Jam. Elden (M. D. or other) \_\_\_\_\_  
Address 1929 Myrtle Date signed 12-27-45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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**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..... *Frederic Walton* .....

Licensed Embalmer No. *2744* .....

P. O. Address *K. C. 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 this body is not embalmed, fact should be so stated above.**