

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35093
STATE FILE NUMBER

FILED NOV 6 1957

Registration District No. 59 Primary Registration District No. 4097 Registrar's No. 159

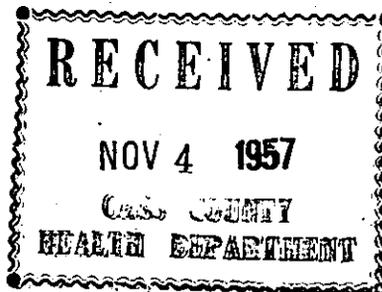
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1. PLACE OF DEATH a. COUNTY <u>Cass</u>		2. USUAL RESIDENCE (Where deceased lived. If in institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cass</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Harrisonville</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Harrisonville</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital give location) HOSPITAL OR INSTITUTION <u>Memorial Hospital</u> Length of stay in lb		d. STREET ADDRESS (If outside, give location) <u>905 E Pearl</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BARBARA LYNN BAILEY</u>			4. DATE OF DEATH Month Day Year <u>Oct 28 1957</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 1 1951</u>
9. AGE (In years last birthday) <u>6</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>in School</u>	11. BIRTHPLACE (City and state or country) <u>Independence Mo</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Wm W. Bailey Jr.</u>	
14. MOTHER'S MAIDEN NAME <u>Donna Deery</u>		15. NAME OF HUSBAND OR WIFE <u>Wm W. Bailey Jr.</u>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		17. SOCIAL SECURITY NO. <u>NONE</u>	18. INFORMANT <u>Wm W. BAILEY JR</u> Address <u>Harrisonville Mo</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Influenza with overwhelming Toxemia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Toxemia</u> DUE TO (c) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Acute obliterative nephritis (left)</u>			
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 Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <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	
21. I attended the deceased from <u>1953</u> to <u>10-28-57</u> and last saw her alive on <u>10-28-57</u> Death occurred at <u>1:45 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Edward S. Jones M.D.</u>		22b. ADDRESS <u>Harrisonville, Mo</u>	22c. DATE SIGNED <u>10-29-57</u>
23a. BURIAL, CREMATION, OR REMOVAL (Specify)	23b. DATE <u>Oct 31 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crest Cemetery</u>	23d. LOCATION (City, town, or county) STATE <u>Harrisonville Mo</u>
24. FUNERAL DIRECTOR <u>Funerary Services Harrisonville</u>		25. DATE RECD. BY LOCAL REG. <u>Oct 31 1957</u>	26. REGISTRAR'S SIGNATURE <u>Dora Barward</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *James R. Phillips*
Licensed Embalmer No. *4641*
P. O. Address *Harrisonville*

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.