

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-035489

STATE FILE NUMBER

FILED NOV 10 1958 Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1185

300  
1-57

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All diseases in Part I must be causally related. No symptoms will be listed. Use only standard nomenclature in item 18. No symptoms will be listed. Dr. S.E. Melune

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Joseph</b>
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>518 N. 3rd Jackson Nursing Home</b>		Length of stay in 1b	6/17 6
3. NAME OF DECEASED (Type or print) <b>Lewis</b>		First <b>Home</b> Middle Last <b>Bailey</b>	4. DATE OF DEATH Month <b>Oct.</b> Day <b>21,</b> Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 4, 1890</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	9. AGE (In years last birthday) <b>67</b>
11. BIRTHPLACE (City and state or country) <b>Mecca, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Pete Bailey</b>		13b. MOTHER'S MAIDEN NAME (correct) <b>Renda Bailey</b>	14. NAME OF HUSBAND OR WIFE <b>Unknown</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>491-10-6232</b>	17. INFORMANT <b>Jeff Robinson</b> Address <b>304 E. Nebr.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>General Arteriosclerosis</b> DUE TO (c) <b>331X</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>Unk.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
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 <input type="checkbox"/> Month, Day, Year a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>			
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 <b>3/21/58</b> to <b>10/21/58</b> and last saw her/him alive on <b>10/21/58</b> Death occurred at <b>10:25 PM</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>S.E. Melune M.D.</b>		22b. ADDRESS <b>214 N. 1st St. St. Joseph Mo.</b>	22c. DATE SIGNED <b>11-5-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Oct. 27, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>City</b>	23d. LOCATION (City, town, or county) (State) <b>St. Joseph MO</b>
24. FUNERAL DIRECTOR <b>Beatrice Gray</b> ADDRESS <b>817 Pacific St</b>		25. DATE RECD. BY LOCAL REG. <b>Nov. 7, 1958</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Goodell</b>

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 *John T. Miles* .....  
Licensed Embalmer No. *3446* .....  
P. O. Address *Atchison, Ka* .....

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.