

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-004865

STATE FILE NUMBER

REGISTRATION DISTRICT NO. 72 PRIMARY REGISTRATION DISTRICT NO. 3013 REGISTRAR'S NO. 25

300  
1-57 0

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>North Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</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 1b <u>10 DAYS</u>	d. STREET ADDRESS (If outside, give location) <u>4450 N. Topping</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Noah</u> Middle <u>Bail</u> Last <u>Bail</u>			4. DATE OF DEATH Month <u>February</u> Day <u>6</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 9, 1886</u>	9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Foundry</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Arbaugh, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13a. FATHER'S NAME <u>Francis M. Bail</u>		13b. MOTHER'S MAIDEN NAME <u>Arena Markins</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Mary Bail</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes W W I</u>		16. SOCIAL SECURITY NO. <u>486-03-1669</u>	17. INFORMANT Address <u>Mrs. Mary Bail-4450 N. Topping K.C. 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>metastatic carcinoma of liver</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>carcinoma of rectum</u>	<u>9 months</u>
	DUE TO (c) <u>None.</u>	
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"/> <u>2</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 <u>6:00</u> Month, Day, Year <u>Feb 9 1959</u> a.m. p.m.		

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 <u>Kansas City 16, Missouri</u>	COUNTY <u>Clay Co</u>	STATE <u>Mo.</u>
21. I attended the deceased from <u>July 28, 1958</u> to <u>February 6, 1959</u> Death occurred at <u>6:00 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		her last saw him alive on <u>February 6, 1959</u>		
22a. SIGNATURE (Degree or title) <u>B. Comer Bates, M.D.</u>		22b. ADDRESS <u>2730 North Wall</u>	22c. DATE SIGNED <u>2/7/59</u>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb 9 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>White Chapel Cemetery</u>	23d. LOCATION (City, town, or county) <u>Clay Co</u>	(State) <u>Mo.</u>
24. FUNERAL DIRECTOR <u>D.W. Newcomer's Sons-No. Kansas City, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>2-8-59</u>	26. REGISTRAR'S SIGNATURE <u>Marguerite Hudgens</u>	

(Licensed Embolmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with or without. All diseases in Part I must be causally related.

MAR 6 1959



STATEMENT BY LICENSED EMBALMER

MAR 6 1959

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 *Edward H. Hill* .....

Licensed Embalmer No. 4586  
P. O. Address K.C. 16, 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.