

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-006968

FILED VS FEB 23 1960

STATE FILE NUMBER

Registration District No. 164 Primary Registration District No. 3032 Registrar's No. 30

1. PLACE OF DEATH a. COUNTY <u>Johnson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Warrensburg</u>	Length of stay in 1b <u>10 Mo</u>	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>Burriess Nursing Home</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>MAY</u> Middle <u>E</u> Last <u>BAILEY</u>	4. DATE OF DEATH Month <u>Feb</u> Day <u>16,</u> Year <u>1960</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>5-10-1912</u>	9. AGE (last birthday) <u>57</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nursing aide</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>	11. BIRTHPLACE (City and state or country) <u>Browning, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>John Frank Bailey</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Etta Long</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <u>no</u> , or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mrs. Ruth Nelson</u> Address <u>Leeton, Missouri</u>
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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>Chronic Myocarditis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Browning, Missouri</u>	COUNTY _____ STATE _____
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21. I attended the deceased from June 1, 57, to 2-16-60 and last saw her alive on 2-16-60
Death occurred at 8:40 P. M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M. D.</u>	22b. ADDRESS <u>Warrensburg, Missouri</u>	22c. DATE SIGNED <u>2-17-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-18-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Browning Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Browning, Missouri</u>
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24. FUNERAL DIRECTOR <u>Wade Funeral Home, Browning, Missouri</u> ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>July 19, 1960</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Richard J. Miller

Licensed Embalmer No. 48288

P. O. Address Wilmington

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.