

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-015130

STATE FILE NUMBER

FILED VS APP 25 1960 149

Primary Registration District No. 1002 Registrar's No. 1901

1901

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Jackson</i>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Kansas City</i>		Length of stay in 1b <i>37 Yrs</i>		c. CITY OR TOWN <i>Kansas City</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St. Joseph Hosp</i>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>6703 W. 11th Rd</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>LOREN S BAILEY</i>				4. DATE OF DEATH Month Day Year <i>APRIL 2 1960</i>				
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>12-1-1902</i>		
9. AGE (last birthday) <i>57</i>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Eng. Father</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Hospital</i>		11. BIRTHPLACE (City and state or country) <i>Jenks MO</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13a. FATHER'S NAME <i>Alfred Bailey</i>			13b. MOTHER'S M maiden name <i>Gertrude Mack</i>			14. NAME OF HUSBAND OR WIFE <i>—</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>487-05-4953</i>		17. INFORMANT <i>Lawrence L Bailey</i> Address <i>452 1/2 North</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Constructive Pericarditis</i> DUE TO (b) <i>metastatic Carcinoma</i> DUE TO (c) <i>Carcinoma of the tongue</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Chronic Bronchitis</i>							INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i> <i>8 weeks</i> <i>3 mos.</i>	
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								
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)				
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 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 <i>9-18-59</i> to <i>April 2-60</i> and last saw ^{her} him alive on <i>April 2-60</i> Death occurred at <i>530</i> <i>o</i> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <i>P. A. Kienberg MD</i>				22b. ADDRESS <i>5246 St John</i>		22c. DATE SIGNED <i>4/4/60</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>April 3, 1960</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt Washburn</i>		23d. LOCATION (City, town, or county) (State) <i>Kansas City MO</i>		
24. FUNERAL DIRECTOR <i>Paul James Home S.P.M.</i> ADDRESS			25. DATE RECD. BY LOCAL REG. <i>4-4-60</i>		26. REGISTRAR'S SIGNATURE <i>neva minshall</i>			

DOCUMENT

BY AFFIDAVIT OF P. A. Kienberg M.D. MEDICAL CERTIFICATION

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



Licensed Embalmer No. 4959

P. O. Address J.P.M.

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.