

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-026941

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3673

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUL 30 1962

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 23 months	c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DOA General No I		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1522 E. 29th St Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First PATRICIA Middle ANN Last BAILEY			4. DATE OF DEATH Month 7 Day 12 Year 62		
5. SEX Female	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-27-1960	9. AGE (last birthday) 1	IF UNDER 1 YEAR Months 11 Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Kans City, MO		12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Charles E. Bailey	13b. MOTHER'S MAIDEN NAME Marcella Carter	14. NAME OF HUSBAND OR WIFE NO
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NO
17. INFORMANT Marcella Wade		Address 1522 E. 29th St Mother

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Asphyxia by Choking		
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) Hypertrophied Thymus Gland		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 type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) Food Particles in Trachea
20c. TIME OF INJURY Hour 7:46 p.m. Month, Day, Year 7/12/62		

20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) 1522 E 29	20f. CITY, TOWN, OR LOCATION Kansas City, Jackson, Mo.	COUNTY Jackson	STATE Mo.
---	--	--	--------------------------	---------------------

21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Deputy Coroner	22b. ADDRESS 1618 Lydia Ave.	22c. DATE SIGNED 7/13/62
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7-16-62	23c. NAME OF CEMETERY OR CREMATORY Mt. St. Mary	23d. LOCATION (City, town, or county) Kans City, Missouri
--	-----------------------------	---	---

24. FUNERAL DIRECTOR Watkins Bros. Funeral Home 18th & Benton	25. DATE RECD. BY LOCAL REG. 7-19-62	26. REGISTRAR'S SIGNATURE Ruth H Long
---	--	---

VS 300
Rev. 4/59

1
2 **3428**
3
4 **3**
5 **C**
6
7 **0**
8 **0**
9 **9210**
10 **22**
11 **123**
12 **72-3**
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

M. Fillman

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

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 Drew P. Watkins

Licensed Embalmer No. 11500

P. O. Address 1824 Benton

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.