MAY 29 1928

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

12478

1. PLACE OF DEATH
County Calloway — Registration District No. 104 — File No.
Township — Primary Registration District No. 3008 — Registered No. 61
City Fulton (No. ..... St. ..... Ward)

2. FULL NAME John Bauer
(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Belle Bauer

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE: 50 Years — Months: Don't Know — Days: — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Don't Know

PARENTS
10. NAME OF FATHER: Don't Know
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): " "
12. MAIDEN NAME OF MOTHER: Don't Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): " "

14. INFORMANT (Address): Hospital records

15. FILED Apr 5, 1928 R. N. Crews REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Apr 5 1928

17. I HEREBY CERTIFY, That I attended deceased from Feb 25, 1928 to Apr 5, 1928 that I last saw him alive on Apr 5, 1928, and that death occurred, on the date stated above, at 8:15 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute dilatation of Heart
38 34 953
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Syphilis
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) G. B. Reeley, M. D.
4-5, 1928 (Address) Fulton Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Shelbyville Mo — DATE OF BURIAL: 4-6 1928

20. UNDERTAKER: J. W. Thompson & Son — ADDRESS: Shelbyville Mo

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.