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

Do not use this space.

4236
File No. 45
Registered No.

1. PLACE OF DEATH
County Shelby Registration District No. 830
Township Salt River Primary Registration District No. 6091
City Shelbina (No. ..... St. ..... Ward)

2. FULL NAME Samuel Henry Baynum

(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.

JAN 22 1931

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	widower

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Mary Tyree

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 12-1844

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	89	5	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Hannibal
(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER John Baynum
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Kans.
12. MAIDEN NAME OF MOTHER not known
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Unknown

14. INFORMANT Mrs. Chas. Bush
(Address) Shelbina Mo.

15. FILED Jan 10 1931 Madge Yeach REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 5, 1931

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1931, to Jan 5, 1931 that I last saw him alive on Jan 5, 1931, and that death occurred, on the date stated above, at 2:00 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia Clinical
Hosp
(duration) ..... yrs. ..... mos. 5 ds.
CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED .....
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) J. A. Furnish, M. D.
1931 (Address) Shelbina 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	DATE OF BURIAL
I.O.O.F. Shelbina	Jan. 7 1931
20. UNDERTAKER J. W. Brothers	ADDRESS Shelbina Mo.

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.

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