

REC'D APR 11 1939

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

10273  
Do not use this space.

1. PLACE OF DEATH 3

(a) County Callaway Registration District No. 104

(b) Township Fulton Primary Registration District No. 3008

(c) City Fulton (d) Street No. State Hospital #1 St. \_\_\_\_\_

(e) Length of residence in city or town where death occurred yrs. 10 mos. 17 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John M. Baysinger

(a) Residence, No. Emow Missouri St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED M (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Rosa Baysinger

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 25, 1864

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.

74 74 5 29

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc. Farmer

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

FATHER

13. NAME Robert W. Baysinger

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

MOTHER

15. MAIDEN NAME Jessie Charity

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jefferson City Missouri

17. INFORMANT (ADDRESS) State Hosp. #1 Records

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Columba DATE 8-26-1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wm. Stapp Russell

20. FILED Mar 25 1939 P. N. Creve Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 24 1939

22. I HEREBY CERTIFY, That I attended deceased from 7:11 38 to 3:44 1939

I last saw him alive on Mar 24 1939 Death is said to have occurred on the date stated above, at 9:00 p.m.

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis

Other contributory causes of importance:  
Psychosis with cerebral arteriosclerosis  
Intubation  
Hypostatic Pneumonia

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No.  
If so, specify \_\_\_\_\_  
(Signed) Geo. F. Wood, M. D.  
11.6 (Address) State Hosp #1 Fulton 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.

14  
22  
22

---

---

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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 this body is not embalmed, above space should be left blank.**