

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.

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

3310  
Do not use this space.

1. PLACE OF DEATH  
(a) County Pettis Registration District No. 668  
(b) Township Sedalia Primary Registration District No. 300 Registered No. 3  
(c) City Sedalia (d) Street No. 250 St.     
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Clyde Berten Bacon  
(a) Residence, No. 1421 East Broadway St.    (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

## 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 Mrs. Madge Bacon

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 3, 1885

7. AGE YEARS 54 MONTHS 2 DAYS    If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Mo. P.  
9. Industry or business in which work was done, as saw mill, bank, etc. Machinist  
10. Date deceased last worked at this occupation (month and year)    11. Total time (years) spent in this occupation   

12. BIRTHPLACE (CITY OR TOWN) Grant (STATE OR COUNTRY) Iowa

13. NAME Rant Bacon  
14. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) Illinois

15. MAIDEN NAME Martha Patterson  
16. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) Ohio

17. INFORMANT Mrs. Madge Bacon (ADDRESS) 1421 E. Broadway, Sedalia, Mo

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Grant, Iowa DATE Jan. 6, 1940

19. FUNERAL DIRECTOR (NAME) Duane Ewing (ADDRESS) Sedalia, Mo

20. FILED Jan 4 19 40 Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) JAN. 3, 19 40

22. I HEREBY CERTIFY. That I attended deceased from as Coroner Base only, 19     
I last saw as Coroner case only Death is said to have occurred on the date stated above, at 9:15 P.M.  
The principal cause of death and related causes of importance were as follows:  
Angina pectoris  
94%

Other contributory causes of importance:  
Chronic myocarditis

Name of operation    Date of     
What test confirmed diagnosis?    Was there an autopsy? No

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 Gordon Hauffacker, M. D.  
(Signed) Coroner 9 Pettis Co  
(Address)

Dr. Mitchell

RECEIVED FILED STATE OFFICE  
INDEX CARD RETURNED TO DISTRICT  
DATE 1-12-40

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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

*Duane Ewing*

Licensed Embalmer No.

*3847*

P. O. Address

*Sedalia Mo*

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.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

3310

Do not use this space.

1. PLACE OF DEATH

(a) County Pettis Registration District No. 668  
(b) Township Sedalia Primary Registration District No. 3232  
(c) City Sedalia (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_  
(Usual place of abode, if no street address, write county or city) (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 (write the word) m  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF Mrs Madge Bacon  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 3 1885  
7. AGE YEARS 84 MONTHS 2 DAYS - If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. m. Pac  
9. Industry or business in which work was done, as saw mill, bank, etc. machinist  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) Great (STATE OR COUNTRY) Town

13. NAME Rant Bacon

14. BIRTHPLACE (CITY OR TOWN) unknown (STATE OR COUNTRY) Illinois

15. MAIDEN NAME Martha Patterson

16. BIRTHPLACE (CITY OR TOWN) Illinois (STATE OR COUNTRY) Illinois

17. INFORMANT (ADDRESS) Mrs Madge Bacon  
1421 Cedar St Sedalia Mo

18. BURIAL, CREMATION, OR REMOVAL Buried DATE 1-6-1940

19. FUNERAL DIRECTOR (ADDRESS) Dr. J. W. Ewing

20. FILED 1-4 1940 Anna Harry Sneed  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-3, 19 40

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
as chronic to coronary

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.  
The principal cause of death and related causes of importance were as follows:

arteriosclerosis

Other contributory causes of importance \_\_\_\_\_

Chronic myocarditis

What test confirmed diagnosis? \_\_\_\_\_ Date of \_\_\_\_\_  
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? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) George H. Stauffer, M. D.  
(Address) Cass Sedalia Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
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.

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