

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **18169**

JUN 17 1940

Registration District No. **194**

Primary Registration District No. **5271**

Registrar's No. **3**

1. PLACE OF DEATH:
(a) County Clark
(b) City or town Wyaconda
(c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 Years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Mrs. Nellie Thomas Bauer
3. (b) If veteran, name war _____ **3. (c) Social Security No.** None

4. Sex Female **5. Color or race** White **6. (a) Single, widowed, married, divorced** Widowed
6. (b) Name of husband or wife Walter **6. (c) Age of husband or wife if alive** _____ years
7. Birth date of deceased Feb. 11, 1892
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>48</u>	<u>2</u>	<u>11</u>	hr. _____ min.

9. Birthplace Davenport, Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business _____

12. Name Jacob Thomas
13. Birthplace Freeport Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Henrietta Hite
15. Birthplace Unknown Pennsylvania
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Joy J. Thomas
(b) Address Davenport, Iowa

17. (a) Burial **(b) Date thereof** 4/25/1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Oakdale Cemetery

18. (a) Signature of funeral director W. J. Thomas
(b) Address Wyaconda, Mo

19. (a) 4-22-40 **(b) Registrar's signature** W. J. Thomas
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Clark
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Wyaconda, Mo
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. day 22 year 40 hour 11:40 minute P. M.

21. I hereby certify that I attended the deceased from Oct 20-39, 19____, to Apr 22, 1940
that I last saw her alive on Apr. 22, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy
Duration 5 hrs.

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Dr. B. P. Hutchinson (M. D. or other) 3
Address Wyaconda, Mo **Date signed** 4/24/40

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.

RECEIVED

District Health Officer No: 10

District File Number ~~6-401048-49~~

JUN 13 1940

Date Filed

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 Geo. B. Baskin

Licensed Embalmer No. 1817

P. O. Address W. J. Baskin

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. ;