

3-40  
-39  
X23150

STANDARD CERTIFICATE OF DEATH

Registered  
State File No. 29919

852 Primary Registration District No. 612 Registrar's No.

Registration District No. 852 Primary Registration District No. 612 Registrar's No.

1. PLACE OF DEATH:  
(a) County Sullivan  
(b) City or town Rural  
(c) Name of hospital or institution Ellis Fischel Hospital, Columbia, Mo.  
(d) Length of stay: In hospital or institution 13 weeks  
In this community All

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Rin  
(c) City or town Burlingame  
(d) Street No.  
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME Mary Eva Bauswell 240

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife A.G. Bauswell 6. (c) Age of husband or wife if alive 41 years

7. Birth date of deceased Aug. 25 1898

8. AGE: Years 41 Months 11 Days 21 If less than one day hr. min.

9. Birthplace Sullivan Co. Mo.

10. Usual occupation House wife

11. Industry or business

12. Name James L. Jones

13. Birthplace Nebraska

14. Maiden name Gertie Brookshire

15. Birthplace Sullivan Co. Mo.

16. (a) Informant G. Bauswell

17. (a) Burial (b) Date thereof 8/17/1940

(c) Place: burial or cremation Knifong-Sullivan, Co.

18. (a) Signature of funeral director W. J. Thorne

(b) Address Laclede, Mo.

19. (a) (b) Registrar's signature

20. DATE OF DEATH: Month Aug day 15 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from June 1940 to Aug 1940 that I last saw her alive on Aug 15 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Bladder. Carcinoma

Due to 52

Due to

Other conditions

Major findings: Of operations

Of autopsy

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?

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

769 While at work? (Specify type of place)

23. Signature Devin K. Heber (M. D. or other) 8/18/40

Address Wilson Date signed 8/18/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 11,

District File Number.....

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..... Me

W. G. Thorne

Registered Apprentice No. 2876

working under my personal supervision.

Signed..... *W. G. Thorne*  
W. G. Thorne

Licensed Embalmer No. 2876

P. O. Address. Laclede, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Thorne Furniture and Undertaking Co.

FUNERAL DIRECTORS: LICENSED EMBALMERS

PHONE 46

LACLEDE, MISSOURI

Harry J. Parker M.A.  
Jefferson City, Mo.  
Dear Sir —

Sept. 28, 1940

*Parker*

Will answer your inquiry as follows Mr. Parker.

Mrs Bauswell, died at her home in Sullivan Co., in the country. She had been in the Columbia Hospital 13 weeks, but was brat home several days before she died.

yours Truly  
W. J. Thorne

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 29919  
Registrar's No. \_\_\_\_\_

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 452

Primary Registration District No. 6122

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
(a) County Sullivan Pleasant  
(b) City or town Rural  
(c) Name of hospital or institution: Ellis Fitchel Hosp Columbia  
(d) Length of stay: In hospital or institution. \_\_\_\_\_  
In this community del (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Sullivan  
(c) City or town Corden (Rural)  
(d) Street No. \_\_\_\_\_  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Mary Eve Bauswell  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: month Aug day 15 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced see  
(b) Name of husband or wife Alva J. Bauswell (c) Age of husband or wife, if alive 42 years  
7. Birth date of deceased: August 25 1898

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

8. AGE: Years 41 Months 11 Days 21 If less than one day \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

9. Birthplace Sullivan Co., Mo. (City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business farmery

12. Name James K. Jones

13. Birthplace Nebraska (City, town, or county) (State or foreign country)

14. Maiden name Ms. Elsie Brock

15. Birthplace Sullivan Co., Mo (City, town, or county) (State or foreign country)

16. (a) Informant A. J. Bauswell

(b) Address Linneus, Mo.

17. (a) Burial (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation Sullivan Co, Mo.

18. (a) Signature of funeral director W. J. Morris

(b) Address Ladoga, Mo.

19. (a) Oct 23 40 (b) Clis Aagon

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_  
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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_