

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

35907

D NOV 6, 1943  
Registration District No. 332

Primary Registration District No. 6115A

State File No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

## 1. PLACE OF DEATH:

(a) County Scott  
(b) City or town Crowder, Mo.  
(c) Name of hospital or institution: 1 - Richland Junc.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution Life (Specify whether years, months or days)

## 3. (a) PRINT FULL NAME

Willie A. Bacon3. (b) If veteran,  
name war \_\_\_\_\_3. (c) Social Security  
No. \_\_\_\_\_4. Sex 7 5. Color or race W 6. (a) Single, widowed, married,  
2 divorced Widow6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years7. Birth date of deceased July 13 - 1868  
(Month) (Day) (Year)8. AGE: Years 85 Months 0 Days 29 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_9. Birthplace Term. I  
(City, town, or county) (State or foreign country)10. Usual occupation House work

## 11. Industry or business

12. Name Bond 7 floors13. Birthplace Middle, Term. I  
(City, town, or county) (State or foreign country)14. Maiden name M. Call15. Birthplace Term. I  
(City, town, or county) (State or foreign country)16. (a) Informant Chas. Cooper(b) Address Crowder, Mo.17. (a) Bond (b) Date thereof Aug 13 - 43  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Miner Switch18. (a) Signature of funeral director Ellis T. Fernald(b) Address St. Louis, Mo.19. (a) Oct 12/43 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Scott  
(c) City or town Crowder, Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 12  
year 1943 hour \_\_\_\_\_ minute 0 M.21. I hereby certify that I attended the deceased from  
43 19 July 12 19 43that I last saw her alive on Aug 8 - 43  
and that death occurred on the date and hour stated above.Immediate cause of death Chromiomyelitis Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions  
(Include pregnancy within 3 months of death)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? \_\_\_\_\_  
(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 Howard Mendi (M. D. or other) \_\_\_\_\_Address St. Louis, Mo. Date signed 9/14/43

RECEIVED

District Health Office No. 2,

District File Number 1148-1401

Date Filed 11-3-43

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 the above constitutes grounds for revocation of license.)

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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. *Nov*

Registration District No. *332*

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

- (a) County *Scott*  
(b) City or town *Crowder*  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME *Wallie A Bacon*

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

4. Sex *F* 5. Color or race *W* 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased *July 13 1885*  
(Month) (Day) (Year)

8. AGE: Years *85* Months *0* Days *0* Unless than one day \_\_\_\_\_ min.

9. Birthplace *Tenn.*  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) *(Mrs. W. H. Foster)*  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Aug* 1943 Year *1943* Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

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

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

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? \_\_\_\_\_  
(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 \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

35907