

17-39  
X29484

**FILED MAR 1945**

Registration District No. **290**

Primary Registration District No. **4427**

Registrar's No. **79**

1. PLACE OF DEATH:  
(a) County **Pulaski**  
(b) City or town **Waynesville**  
(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 **Life** \_\_\_\_\_ (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Pulaski**  
(c) City or town **Waynesville, Mo.**  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **John Green Bales**

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

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

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

7. Birth date of deceased **Feb. 5, 1927**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>17</b>	<b>11</b>	<b>20</b>	_____ hr. _____ min.

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

10. Usual occupation **None**

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

12. Name **John Bales**

13. Birthplace **Pulaski Co. Mo.**  
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Rickerson**

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

16. (a) Informant **John Bales**

(b) Address **Waynesville, Mo.**

17. (a) **burial** (b) Date thereof **1/27/45**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Gospel Ridge Cem.**

18. (a) Signature of funeral director **J. L. Hoops & Sons**

(b) Address **Crocker, Mo.**

19. (a) **2-19-45** (b) **Charm Dell**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **25th**  
year **1945** hour **7** minute **30** A. M.

21. I hereby certify that I attended the deceased from **June 7, 1942** to **Jan 23, 1945**  
that I last saw him alive on **Jan 23, 1945**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Tuberculosis**

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

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

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

**ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED**

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 **R.O. Dewitt** (M.D. or other) **2**

Address **Waynesville Mo.** Date signed **2-10-45**

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

MOTHER FATHER

1170

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.

*Not Embalmed*

Signed *Paul B Hooper*  
Licensed Embalmer No. *3761*  
P. O. Address *Waynesville, N.C.*

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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 6902  
Registrar's No. 74

Registration District No. 290 Primary Registration District No. 4427

1. PLACE OF DEATH:  
(a) County Pulaski  
(b) City or town Waynesville  
(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 John H. Bales  
3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced 3

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

7. Birth date of deceased 9/25/51  
(Month) (Day) (Year)

8. AGE: Years 17 Months Days If less than one day hr. min.

9. Birthplace MO  
(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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (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 12 year 1945 hour minute M.

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

Pulmonary tuberculosis

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy 13/1

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 P. O. Dewitt (M. D. or other) L. 80.  
Address Waynesville Mo Date signed 3-29-46

SUPPLEMENTARY

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

1000