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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 16 1947
202

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31995**
Registrar's No. **15**

Registration District No. _____ Primary Registration District No. **4394**

1. PLACE OF DEATH:
(a) County **Frank**
(b) City or town **Bakersfield**
(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) **60 years**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Osage**
(c) City or town **Bakersfield**
(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 _____

3. (a) PRINT FULL NAME **Sam Wesley Bales**
3. (b) If veteran, name war _____ **3. (c) Social Security** No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **8** day **24**
year **1947** hour **6** minute **30** AM
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____.

4. Sex **Male** **5. Color or race** **White**
6. (a) Single, widowed, married, divorced **M**
6. (b) Name of husband or wife **Elizabeth Bales** **6. (c) Age of husband or wife if** alive _____ years
7. Birth date of deceased. **Sept 29 - 1867**
(Month) (Day) (Year)

that I last saw h. _____ alive on _____, 19____, and that death occurred on the date and hour stated above.
Immediate cause of death. _____
Duration _____

8. AGE: Years **79** Months **10** Days **25** If less than one day _____
9. Birthplace. _____ (City, town, or county) _____ (State or foreign country)

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

10. Usual occupation **farmer**
11. Industry or business _____
12. Name **Ephraim Bales**
13. Birthplace **Bakersfield Mo**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary**
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

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 _____

16. (a) Informant **Charley Bales**
(b) Address **Bakersfield Mo**
17. (a) _____ (Burial, cremation, or removal) **(b) Date thereof** **8-25-47**
(Month) (Day) (Year)
(c) Place: burial or cremation **Bakersfield Mo**
18. (a) Signature of informant _____
(b) Address **Franklin, Mo**
19. (a) **Sept. 5 - 47** (b) **W. Davis**
(Date received local registrar) (Registrar's signature)

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

PHYSICIAN

Underline the cause of death which death certificate is to be charged statistically.
ADDITIONAL SUPPLEMENTARY INFORMATION

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 with 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 CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. *act*Registration District No. *262*Primary Registration District No. *4394*Registrar's No. *15-*

1. PLACE OF DEATH:

- (a) County *garr*
 (b) City or town *Bakerfield*
 (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 *Sam W. 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 *m*6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____7. Birth date of deceased *Sept 29*
(Month) (Day) (Year)8. AGE: Years *79* Months *10* Days *20* If less than one day
_____ hr. _____ min.9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) *Sept 5 - 1947* (b) *Carl Davis*
(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 *Sept* Day *5* Year *1947* hour *3:00* minute *PM*

21. I hereby certify that I attended the deceased from _____ to _____, 19____

that I last saw him _____ and that death occurred on the date and hour stated above.
Immediate cause of death *a poplexy*

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 *Carl Davis* (M.D. or other) *J.R.*
Address *Udall Mo* Date signed *10-1-47*

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

SUPPLEMENTARY

S-31995-