

FILED JAN 3 1949

Registration District No. 141

Primary Registration District No. 5551

Registrar's No. 58

1. PLACE OF DEATH:

(a) County Howell
(b) City or town West Plains, Mo
(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 36 years (Specify whether)
In this community 36 years
years, months or days

3. (a) PRINT FULL NAME Root B. Bale

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 SM
6. (b) Name of husband or wife Ora Bale 6. (c) Age of husband or wife if alive 69 years
7. Birth date of deceased 6-15-1871
(Month) (Day) (Year)

8. AGE: Years 77 Months 5 Days 18 If less than one day
hr. min.

9. Birthplace Green Co., Ky.
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

12. Name Joe I. Bale

13. Birthplace Green Co., Ky.
(City, town, or county) (State or foreign country)

14. Maiden name Anna Middleton

15. Birthplace Green Co., Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Ora Bale

(b) Address West Plains, Mo

17. (a) B (b) Date thereof 12-5-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ELK Creek

18. (a) Signature of funeral director Robertson

(b) Address West Plains, Mo

19. (a) Dec 21-48 (b) Beatrice Cook
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell
(c) City or town West Plains, 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 Dec day 3
year 1948 hour 2:45 P minute 0 M.

21. I hereby certify that I attended the deceased from 11-15-48 to 12-3-48
that I last saw him alive on 12-1-48
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Nephritis Duration 2 yrs

Due to Arteriosclerosis general 10 yrs.

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?

(Specify type of place) While at work (c) Means of injury

23. Signature W. D. Callahan M.D. (M. D. or other)

Address West Plains, Mo Date signed 12/4/48

RECEIVED 12-27-48
District Health Officer No. 5,
District File Number 1248798
Date Filed 12-27-48

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. 4480

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.