

FILED MAY 24 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 18127

18127

|  |  |  |   |   |  |  |  |
|--|--|--|---|---|--|--|--|
| BIRTH NO. _____  |  | REG. DIST. NO. <u>364</u>  |   | PRIMARY REG. DIST. NO. <u>453</u>   |  | Registrar's No. <u>3</u>   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Warren</u>   |  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>Mo</u><br>b. COUNTY <u>Warren</u>              |  |  |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br><u>Rural Hickory Grove</u>   |  |  | c. LENGTH OF STAY (In this place)<br><u>1</u> |   |  | c. CITY (If outside corporate limits, write RURAL and give township)<br><u>Rural Hickory Grove</u> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><u>Home T.F.D.</u>  |  |  |   | d. STREET ADDRESS (If rural, give location)<br><u>Marthasville T.F.D.</u>   |  |  |  |
| 3. NAME OF DECEASED<br>(Type or Print)   |  | a. (First)<br><u>Alfred</u>  |   | b. (Middle)<br><u>Snowdon</u>   |  | c. (Last)<br><u>Bear</u>   |  |
| 4. DATE OF DEATH   |  | (Month)<br><u>4</u>  |   | (Day)<br><u>28</u>  |  | (Year)<br><u>49</u>  |  |
| 5. SEX<br><u>M</u>   |  | 6. COLOR OR RACE<br><u>White</u>   |   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Married</u>  |  | 8. DATE OF BIRTH<br><u>April 23 1870</u>   |  |
| 9. AGE (In years last birthday)<br><u>79</u>   |  | IF UNDER 1 YEAR<br>Months<br><u>5</u>  |   | IF UNDER 24 HRS.<br>Days<br><u>5</u>  |  | IF UNDER 24 HRS.<br>Hours<br><u>1</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done regularly and continuing, even if retired)<br><u>Retired Farmer</u>  |  |  |   | 10b. KIND OF BUSINESS, OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Cooper Co Mo</u>                                   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>  |  |  |   | 13a. FATHER'S NAME<br><u>John Henry Bear</u>  |  | 13b. MOTHER'S MAIDEN NAME<br><u>Mary Morris</u>  |  |
| 14. NAME OF HUSBAND OR WIFE<br><u>Mary Nancy Bear</u>  |  |  |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><input checked="" type="checkbox"/> Yes |  | 16. SOCIAL SECURITY NO.<br><input checked="" type="checkbox"/>                                     |  |
| 17. INFORMANT'S SIGNATURE OR NAME<br><u>Malcolm Bear</u>   |  |  |   | ADDRESS<br><u>Marthasville Mo</u>   |  |  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.  |  |  |   |   |  |  |  |
| MEDICAL CERTIFICATION  |  |  |   |   |  |  |  |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>  |  |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>Immediate</u>   |  |
| ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Generalized Arteriosclerosis</u>  |  |  |   |   |  | <u>5 yrs</u>   |  |
| DUE TO (c) _____   |  |  |   |   |  |  |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <u>Carcinoma of Prostate</u>   |  |  |   |   |  | <u>331X</u>  |  |
| 19a. DATE OF OPERATION   |  | 19b. MAJOR FINDINGS OF OPERATION   |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)   |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |   | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)   |  |  |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)   |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |   | 21f. HOW DID INJURY OCCUR?  |  |  |  |
| 22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>46</u> , to <u>April</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>4-26</u> , 19 <u>49</u> , and that death occurred at <u>6:30 p.</u> m., from the causes and on the date stated above. |  |  |   |   |  |  |  |
| 23a. SIGNATURE (Degree or title)<br><u>Raymond A. Hughes, M.D.</u>   |  |  |   | 23b. ADDRESS<br><u>Wright City, Mo.</u>   |  | 23c. DATE SIGNED<br><u>4-29-49</u>   |  |
| 24a. BURIAL, CREMATION, REINTERMENT  |  | 24b. DATE<br><u>Apr May 1/49</u>   |   | 24c. NAME OF CEMETERY OR CREMATORY<br><u>Wright City Cem</u>  |  | 24d. LOCATION (City, town, or county) (State)<br><u>Wright City Mo</u>                             |  |
| DATE REC'D BY LOCAL REG.<br><u>May 16-49</u>   |  | REGISTRAR'S SIGNATURE<br><u>Mrs F. W. Hughes</u>   |   | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><u>Nieburg Furn &amp; Und Co Wright City</u>  |  |  |  |

DEC 5 0 1949

RECEIVED  
District Health Officer No. 9,  
District File Number  
MAY 23 1949  
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 \_\_\_\_\_

..... Student Embalmer No. ....  
working under my personal supervision.

Student .....  
Student Embalmer

Signed Julius J. Fishberg  
Licensed Embalmer No. 3366

P. O. Address Wright City, Mo

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.