

FILED DEC 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43403**

BIRTH NO. _____ REG. DIST. NO. **333** PRIMARY REG. DIST. NO. **6116** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY SCOTT		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MINER SWITCH b. COUNTY SCOTT	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN RURAL 6116) c. LENGTH OF STAY (in this place) 2 MONTHS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL 6116	
d. FULL NAME OF HOSPITAL OR INSTITUTION MINER SWITCH, MO		d. STREET ADDRESS (If rural, give location) MINER SWITCH, MO	
3. NAME OF DECEASED a. (First) DEWITT b. (Middle) D c. (Last) BAWCUM		4. DATE OF DEATH (Month) (Day) (Year) DEC 10 1949	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH MARCH 9 1898
9. AGE (In years last birthday) 51		10. KIND OF BUSINESS OR INDUSTRY FARMER	11. BIRTHPLACE (State or foreign country) TENNESSEE
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME ANISON BAWCUM		13b. MOTHER'S MAIDEN NAME BELLE KIRK	
14. NAME OF HUSBAND OR WIFE LILY BALLANGER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME JAMES T BLEDSOE ADDRESS _____	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral apoplexy ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION NONE		19b. MAJOR FINDINGS OF OPERATION NONE	
20. AUTOPSY? 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) MINER SWITCH SCOTT MO	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		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 Nov 20, 1949 , to Nov 20, 1949 , that I last saw the deceased alive on Nov 20, 1949 , and that death occurred at 10 P. m., from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) Wm. C. Citchlow, M.D.		23b. ADDRESS Subston, MO	
23c. DATE SIGNED Dec 11, 1949		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE Dec 12-49		24c. NAME OF CEMETERY OR CREMATORY Yellow Springs	
24d. LOCATION (City, town, or county) (State) Decatur Co, Tenn		25. FUNERAL DIRECTOR'S SIGNATURE O. F. Talley ADDRESS _____	
DATE REC'D BY LOCAL REG. Dec 11-49		REGISTRAR'S SIGNATURE Mrs. E. H. Hanks	

(Licensed Embalmer's Statement on Reverse Side)

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

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RECEIVED DEC 19 1949
District Health Office No. 2,
District File Number 1249-1269
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.

Signed *C. W. Reed* _____

Signed _____
Student Embalmer

Licensed Embalmer No. 1494

P. O. Address Jefferson Tn

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.