

BIRTH NO. 25518-50 REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 61

1. PLACE OF DEATH a. COUNTY Scott		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Stoddard	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sikeston		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Dexter - 1030	
c. LENGTH OF STAY (In this place) 5 hrs.		d. STREET ADDRESS (If rural, give location) Route # 4 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Delta Comm. Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Alan b. (Middle) Wayne c. (Last) Bilderback			4. DATE OF DEATH (Month) (Day) (Year) April 5, 1950		
5. SEX Male <input checked="" type="checkbox"/>		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED. (Specify) NEW BORN	
8. DATE OF BIRTH April 5, 1950			9. AGE (In years last birthday) 5		IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) New Born			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Sikeston, Missouri 0
12. CITIZEN OF WHAT COUNTRY? U.S.					

13a. FATHER'S NAME Wayne Bilderback		13b. MOTHER'S MAIDEN NAME Bonnie Louise Hughes		14. NAME OF HUSBAND OR WIFE None	
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 ADDRESS Mother - Bonnie Louise Bilderback	

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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Pulmonary Atelectasis</i>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		7620	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		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)	
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 4-5 1950, to 4-5, 1950, that I last saw the deceased alive on 4-5, 1950, and that death occurred at 6:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>Allen R. Sargent M.D.</i>		23b. ADDRESS Sikeston, Mo.		23c. DATE SIGNED 4-7-50	
24a. BURIAL, CREMATION REMOVAL (Specify) Removal		24b. DATE 4-6-50		24c. NAME OF CEMETERY OR CREMATORY Bernie Cemetery	
24d. LOCATION (City, town, or county) (State) Bernie Mo.					

DATE REC'D BY LOCAL REG. Apr 12 50		REGISTRAR'S SIGNATURE <i>Mrs. Ella Hunter</i>		5. FUNERAL DIRECTOR'S SIGNATURE By: <i>Ray W. Grange</i>	
				ADDRESS Dexter, Mo.	

RECEIVED **APR 17 1950**

SCOTT COUNTY HEALTH CENT

CO. FILE NO. 450-1

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.....

Licensed Embalmer No.....

P. O. Address.....

Not embalmed

Note: The above **MUST BE SIGNED** BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

*If this body is not embalmed, fact should be so stated above.