

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. **7894**

FILED MAR 26 1952

BIRTH NO. _____ REG. DIST. NO. **100** PRIMARY REG. DIST. NO. **3018** Registrar's No. **19**

1. PLACE OF DEATH a. COUNTY Dent				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Dent			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Salem				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Salem			
d. FULL NAME OF HOSPITAL OR INSTITUTION XX				d. STREET ADDRESS (If rural, give location) X			
3. NAME OF DECEASED (Type or Print) a. (First) John Wesley b. (Middle) Babb c. (Last) _____				4. DATE OF DEATH (Month) (Day) (Year) 3/13/52			
5. SEX male		6. COLOR OR RACE w		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH April 27/1397	
9. AGE (In years last birthday) 54		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief of Police				10b. KIND OF BUSINESS OR INDUSTRY City Salem		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13a. FATHER'S NAME Lyman Babb				13b. MOTHER'S MAIDEN NAME Tenn. Tipton		14. NAME OF HUSBAND OR WIFE Lola Babb	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or date of service) 1st W. War				16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Lola Babb ADDRESS Salem Mo	
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, asthenia, etc. It means the disease, injury, or complication which caused death. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) coronary artery disease ANTECEDENT CAUSES Morbidity 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. 19a. DATE OF OPERATION _____				19b. MAJOR FINDINGS OF OPERATION 4201			
20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (Min.) _____		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 1950 , 19____, to 3-13 , 19 52 , that I last saw the deceased alive on 3-13 , 19 52 , and that death occurred at 7:00 P. m. , from the causes and on the date stated above.							
23a. SIGNATURE Jas. W. Jones, M.D. (Degree or title) 2				23b. ADDRESS Salem Mo		23c. DATE SIGNED 3-18-52	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 3/16/52		24c. NAME OF CEMETERY OR CREMATORY Cedar Grove		24d. LOCATION (City, town, or county) (State) Salem Mo	
DATE REC'D BY LOCAL REG. 3-18-52		REGISTRAR'S SIGNATURE M. D. Hart, M.D. by MRS. J. W. Jones		25. FUNERAL DIRECTOR'S SIGNATURE Chas. W. Jones ADDRESS Salem Mo			

(Licensee Embalmer's Statement on Reverse Side)

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

8361

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_____

working under my personal supervision.

Student
Student Embalmer

Student Embalmer No.

Signed

Carl H. Spruill

Licensed Embalmer No. *2370*

P. O. Address *Salisbury, Md*

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.