

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3610

State File No.

FILED FEB 9 1954

BIRTH NO. _____ REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 3072 Registrar's No. 19

0972

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

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <i>Saline</i> | | 2. USUAL RESIDENCE (Where deceased lived immediately before death) a. STATE <i>Mo</i> b. COUNTY <i>Saline</i> | |
| b. CITY OR TOWN <i>Marshall</i> | | c. CITY OR TOWN <i>Slater</i> | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. LENGTH OF STAY (in this place) <i>12 Hours</i> | | e. STREET ADDRESS (If rural, give location) <i>729-North Elm Street</i> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <i>Figgilbon Hospital</i> | | | |

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|--|-------------|-----------|--------------------------------------|-------|--------|
| 3. NAME OF DECEASED (Type or Print) <i>WILBUR FISK BALES</i> | | | 4. DATE OF DEATH <i>Febry-1-1954</i> | | |
| a. (First) | b. (Middle) | c. (Last) | (Month) | (Day) | (Year) |

| | | | | | |
|--------------------|-------------------------------|--|-------------------------------------|--|-----------------------------------|
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH <i>June-3-1887</i> | 9. AGE (In years last birthday) <i>66-7-28</i> | 10. IF UNDER 18 HAS: Hours Min. |
|--------------------|-------------------------------|--|-------------------------------------|--|-----------------------------------|

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|---|--|-----------------------------------|--|---|--|---|--|
| 10a. USUAL OCCUPATION (Give kind of work during most of working life, if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTH PLACE (City and State or Foreign Country) <i>Florence, Colorado</i> | | 12. CITIZENSHIP OF BIRTH COUNTRY <i>USA</i> | |
|---|--|-----------------------------------|--|---|--|---|--|

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|--|--|--|--|---|--|
| 13a. FATHER'S NAME <i>Wilbur Bales</i> | | 13b. MOTHER'S MAIDEN NAME <i>Jennie Saltmire</i> | | 14. NAME OF HUSBAND OR WIFE <i>Alvina Bales</i> | |
|--|--|--|--|---|--|

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|---|--|---|--|--|--|-------------------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>709-109378</i> | | 17. INFORMANT'S SIGNATURE, OR NAME <i>Warren H. Bales, Kansas City</i> | | ADDRESS No. _____ | |
|---|--|---|--|--|--|-------------------|--|

| | | | | | | | |
|--|--|---|--|-----------------------------------|--|----------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| *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) <i>Chronic Nephritis with Uremia</i> | | DUE TO (b) <i>Ch. Myocarditis</i> | | <i>3 wks</i> | |
| | | ANTECEDENT CAUSES | | DUE TO (c) <i>Chronic Asthma</i> | | <i>7 years?</i> | |
| | | 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 | | 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) | |
|--|--|--|--|---|--|

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|--|--|---|--|----------------------------|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |
|--|--|---|--|----------------------------|--|

22. I hereby certify that I attended the deceased from *12-12, 1950* to *Feb 1, 1954*, that I last saw the deceased alive on *Jan 31, 1954* and that death occurred at *1:50 PM* from the causes and on the date stated above.

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|---|--|---------------------------------|--|--------------------------------|--|
| 23a. SIGNATURE <i>W. M. C. Sumner, M.D.</i> (Degree or title) | | 23b. ADDRESS <i>Slater, Mo.</i> | | 23c. DATE SIGNED <i>2/3/54</i> | |
|---|--|---------------------------------|--|--------------------------------|--|

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| 24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24b. DATE <i>2-3-54</i> | | 24c. NAME OF CEMETERY OR CREMATORY <i>Slater City Cemetery</i> | | 24d. LOCATION (City, town, or county) (State) <i>Slater, Mo.</i> | |
|---|--|-------------------------|--|--|--|--|--|

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| DATE REC'D BY LOCAL REG. <i>2-3-54</i> | | REGISTRAR'S SIGNATURE <i>Sidney J. Gray</i> | | 25. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Jones</i> | | ADDRESS <i>Slater, Mo.</i> | |
|--|--|---|--|---|--|----------------------------|--|

MAR 10 1954

FEB 11 1954

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
Signature of Student Embalmer

Signed *James E. Jones*
Licensed Embalmer No. *31*
P. O. Address *State*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.