

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30443

State File No. \_\_\_\_\_

FILED SEP 20 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 141 PRIMARY REG. DIST. NO. 5551 Registrar's No. 34

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><u>HOWELL</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE<br><u>MISSOURI</u> |  | b. COUNTY<br><u>HOWELL</u>  |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN<br><u>WEST PLAINS, MISSOURI</u> |  | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN<br><u>WEST PLAINS,</u>                |  | d. STREET ADDRESS (If rural, give location)<br><u>R.F.D. 0460</u> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><u>x Rural</u>   |  | d. STREET ADDRESS   |  | 0   |  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) <u>BERTIE</u> b. (Middle) <u>E.</u> c. (Last) <u>BACON</u> |  |  | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br><u>8-14-54</u> |  |  |
|---|--|--|--|--|--|

|                    |                              |  |                                      |  |                                       |                                      |                                     |                                    |
|--------------------|------------------------------|--|--------------------------------------|--|---------------------------------------|--------------------------------------|-------------------------------------|------------------------------------|
| 5. SEX<br><u>F</u> | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>M</u> | 8. DATE OF BIRTH<br><u>6-19-1880</u> | 9. AGE (In years last birthday)<br><u>74</u> | IF UNDER 1 YEAR<br>Months<br><u>1</u> | IF UNDER 1 YEAR<br>Days<br><u>25</u> | IF UNDER 1 YEAR<br>Hours<br><u></u> | IF UNDER 1 YEAR<br>Min.<br><u></u> |
|--------------------|------------------------------|--|--------------------------------------|--|---------------------------------------|--------------------------------------|-------------------------------------|------------------------------------|

|   |   |   |  |
|---|---|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>housewife</u> | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>X</u> | 11. BIRTHPLACE (State or foreign country)<br><u>SALEM, MISSOURI</u> | 12. CITIZEN OF WHAT COUNTRY?<br><u>U S A</u> |
|---|---|---|--|

|  |  |   |
|--|--|---|
| 13a. FATHER'S NAME<br><u>GEORGE BENN</u> | 13b. MOTHER'S MAIDEN NAME<br><u>MOLLIE MEEFORD</u> | 14. NAME OF HUSBAND OR WIFE<br><u>S. D. BACON</u> |
|--|--|---|

|  |                                      |  |                                   |
|--|--------------------------------------|--|-----------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>X</u> | 16. SOCIAL SECURITY NO.<br><u>NO</u> | 17. INFORMANT'S SIGNATURE OR NAME<br><u>SYBLE HOLBROOK</u> | ADDRESS<br><u>WEST PLAINS, 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. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 days</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>Senile Heart Disease</u> |  |   |
|   | DUE TO (c) <u>Chronic Bronchitis</u>  |  | <u>YEARS</u>                                      |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |   |  |   |

|                        |   |   |
|------------------------|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION<br><u>4343</u> | 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) | 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 Aug 7, 1952 to 8-14, 1954, that I last saw the deceased alive on 8-13, 1954, and that death occurred at 7:00 PM from the causes and on the date stated above.

|  |                   |   |                                    |
|--|-------------------|---|------------------------------------|
| 23a. SIGNATURE<br><u>Jack N. Wiles, M.D.</u> | (Degree or title) | 23b. ADDRESS<br><u>West Plains, Mo.</u> | 23c. DATE SIGNED<br><u>8-26-54</u> |
|--|-------------------|---|------------------------------------|

|  |                             |   |   |
|--|-----------------------------|---|---|
| 24a. BURIAL CREMATION, REMOVAL (Specify)<br><u>B</u> | 24b. DATE<br><u>8-16-54</u> | 24c. NAME OF CEMETERY OR CREMATORY<br><u>HOMELAND</u> | 24d. LOCATION (City, town, or county) (State)<br><u>WEST PLAINS, MO</u> |
|--|-----------------------------|---|---|

|  |   |   |                                   |
|--|---|---|-----------------------------------|
| DATE REC'D BY LOCAL REG.<br><u>9-13-54</u> | REGISTRAR'S SIGNATURE<br><u>Beatrice Cook</u> | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>ROBERTSONS</u> | ADDRESS<br><u>WEST PLAINS, MO</u> |
|--|---|---|-----------------------------------|

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

No. 300  
10.48

460

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 *J. Roberts* .....

Licensed Embalmer No. *3430* .....

P. O. Address *West Haven* .....

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.