

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

DR. GOSE & MAR 33562  
State File No. ....

FILED NOV 8 - 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 1041

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MO</b> b. COUNTY <b>Howell</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>SPRINGFIELD, MO</b>		c. LENGTH OF STAY (In this place)	c. CITY OR TOWN <b>PAMOMA, MO</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. JOHNS HOSPITAL</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <u>260</u>	
e. STREET ADDRESS (If rural, give location) <b>FIRST TOWN SOUTH OF WEST PLAINS</b>			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) <b>AMANDA</b>	b. (Middle) <b>JOSEPHINE</b>	c. (Last) <b>BAUER</b>	<b>NOV</b>		<b>11 1954</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>APRIL 30, 1890</b>	9. AGE (In years last birthday) <b>64</b>	IF UNDER 1 YEAR Days
10a. USUAL OCCUPATION (Give kind of work conducting most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSE</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>ARKANSAS</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME <b>KINMAN</b>	14. NAME OF HUSBAND OR WIFE <b>HENRY J. BAUER</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) <b>NO</b> (If yes, give war and dates of service)	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT'S SIGNATURE OR NAME <b>DOROTHY ROBERTSON</b> ADDRESS <b>WEST PLAINS</b>
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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; assthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Diabetes mellitus</b>		
	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. <b>Thrombosis of femoral artery</b>		<b>5 days</b>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <b>260</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 \_\_\_\_\_, 19\_\_\_\_, to 11-1, 1954, that I last saw the deceased alive on 11-1, 1954, and that death occurred at 5 P. m., from the causes and on the date stated above.

23a. SIGNATURE <b>Armed C. Marshall, M.D.</b> (Print or title)	23b. ADDRESS <b>Professional Bldg.</b>	23c. DATE SIGNED <b>11-3-54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <b>Nov 1, 1954</b>	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) <b>West Plains, Missouri</b>
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DATE REC'D BY LOCAL REG. <b>11/4/54</b>	REGISTRAR'S SIGNATURE <b>James Williamson</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Herman Johnson</b> ADDRESS <b>Springfield Missouri</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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, ~~\_\_\_\_\_~~....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *H. J. McCann*.....

Licensed Embalmer No. *272*.....

P. O. Address *Springfield*.....

**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.