

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

40746

FILED JAN 10 1955

BIRTH NO.		REG. DIST. NO. <u>141</u>		PRIMARY REG. DIST. NO. <u>3025</u>		Registrar's No. <u>70</u>	
1. PLACE OF DEATH a. COUNTY <u>HOWELL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>HOWELL</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>WEST PLAINS, MO</u>		c. LENGTH OF STAY, (In this place) <u>48 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>WEST PLAINS,</u>		<u>0461</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>X</u>				d. STREET ADDRESS (If rural, give location) <u>403 W. 1st.,</u>			
3. NAME OF DECEASED (Type or Print) <u>ALLIE M. BACON</u>		a. (First)		b. (Middle)		c. (Last)	
4. DATE OF DEATH <u>11-27-54</u>		(Month)		(Day)		(Year)	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>M</u>		8. DATE OF BIRTH <u>5-4-1888</u>	
9. AGE (In years last birthday) <u>74</u>		If UNDER 1 YEAR Months		If UNDER 1 YEAR Days		If UNDER 1 YEAR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>X</u>		11. BIRTHPLACE (State or foreign country) <u>BEAUGARD, MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13a. FATHER'S NAME <u>OLIVER BUNTIN</u>		13b. MOTHER'S MAIDEN NAME <u>ELIZABETH MILLER</u>		14. NAME OF HUSBAND OR WIFE <u>J. W. BACON,</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>X</u>		16. SOCIAL SECURITY NO. <u>X</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>J. W. BACON, WEST PLAINS, MO</u>			
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) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <u>Essential Hypertension</u> 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.		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <u>331X</u> 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) m.		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 <u>11-27, 1954</u> , to <u>11-27, 1954</u> , that I last saw the deceased alive on <u>11-27, 1954</u> , and that death occurred at <u>8:00 PM</u> from the causes and on the date stated above.							
23. SIGNATURE (Degree of title) <u>Dr. Richard A. Smith D.O.</u>		23b. ADDRESS <u>West Plains, Mo.</u>		23c. DATE SIGNED <u>12-10-54</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		24b. DATE <u>11-30-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>CAK LAWN</u>		24d. LOCATION (City, town, or county) (State) <u>WEST PLAINS, MO</u>	
DATE REC'D BY LOCAL REG. <u>1-6-55</u>		REGISTRAR'S SIGNATURE <u>Beatrice Cooke</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>ROBERTSONS, WEST PLAINS, MO</u>			

(Licensed Embalmer's Statement on Reverse Side)

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, or by.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

D. D. Roberts

Licensed Embalmer No. *3487*

P. O. Address *West Ham*

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.