

No. 300
10-48

FILED SEP 9 1955

STANDARD CERTIFICATE OF DEATH

State File No. 27064

BIRTH NO. _____ REG. DIST. NO. 236 PRIMARY REG. DIST. NO. 4352 Registrar's No. 48

1. PLACE OF DEATH a. COUNTY Morgan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Moniteau	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Versailles	c. LENGTH OF STAY (In this place) 9 Months	c. CITY OR TOWN Tipton	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Kidwell Rest Home		e. STREET ADDRESS (If rural, give location) 7 Mi. N.E. Tipton 06 80 1	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Dessie	b. (Middle) Agnes	c. (Last) Bear	(Month) Sept.	(Day) 1.	(Year) 1955

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH July, 5, 1880	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months	IF UNDER 6 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and State or Foreign Country) Cooper County, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Creed Powell	13b. MOTHER'S MAIDEN NAME Lou Breden	14. NAME OF HUSBAND OR WIFE Hugh Bear (Deceased)
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs. Elnor Newkirk, Tipton, Mo	ADDRESS
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES DUE TO (b) Hypertension		7 yrs
	DUE TO (c) 332X		
	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"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from April 10, 1948, to 8-1-, 1955, that I last saw the deceased alive on 3-23, 1955, and that death occurred at 7 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
<i>[Signature]</i>	Tipton, Mo	8-2-55

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept. 3, 1955	24c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery	24d. LOCATION (City, town, or county) (State) Tipton, Missouri
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DATE REC'D BY LOCAL REG. 9-6-55	REGISTRAR'S SIGNATURE <i>[Signature]</i>	F. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>	ADDRESS
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(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.....
Signature of Student Embalmer

Signed..... *Jesse E. Rich*

Licensed Embalmer No. *246*
P. O. Address *Lipton*

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.