

32401

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

No. 300
10.48

FILED NOV 1 1955

BIRTH NO. _____ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 280

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fulton</u>	c. LENGTH OF STAY (In this place) <u>5 month</u>	c. CITY OR TOWN <u>Guthrie</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Mo State Hosp no 1</u>		e. STREET ADDRESS (If rural, give location) <u>0140</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Ular</u> b. (Middle) <u>Baynham</u> c. (Last) <u>Baynham</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 23, 1955</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>divorced</u>	8. DATE OF BIRTH <u>Apr 19</u>	9. AGE (In years last birthday) <u>73</u>	IF UNDER 1 YEAR Months Days	IF UNDER 1 HR. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farmer</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>Doc Baynham</u>	13b. MOTHER'S MAIDEN NAME <u>Foster Hill</u>	14. NAME OF HUSBAND OR WIFE <u>Doc</u>
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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) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Argyle Baynham</u> ADDRESS <u>Guthrie Mo</u>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Generalized arteriosclerosis</u>		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) _____ DUE TO (c) <u>4500</u>			
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 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 May 10, 1951, to Oct 23, 1955, that I last saw the deceased alive on Oct 23, 1955, and that death occurred at 7:15 Am., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>J. R. Hunter M.D.</u>	23b. ADDRESS <u>Fulton Mo</u>	23c. DATE SIGNED <u>Oct 23/55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>10/26/55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St Pauls MC Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>New Bloomfield Mo</u>
DATE REC'D BY LOCAL REG. <u>Oct 26-1955</u>	REGISTRAR'S SIGNATURE <u>Martha Lawrence</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Walt Clayton Funeral D.B. 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.....
Signature of Student Embalmer

Signed *L. Perry Claypool*.....
Licensed Embalmer No. *441*.....
P. O. Address *New Bloom*.....

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.