

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31559

STATE FILE NUMBER

FILED SEP 16 1957

Registration District No. 1-33 Primary Registration District No. 5483 Registrar's No. 49

S. 300
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1. PLACE OF DEATH a. COUNTY <u>Harrison</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Harrison</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural Bethany Twp</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Rural Bethany Twp</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>at home</u> Length of stay in lb <u>20 yr</u>		d. STREET ADDRESS (If outside, give location) <u>4 Miles S.W. Bethany</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Julia Frances Bacon</u>			4. DATE OF DEATH Month Day Year <u>9-10-57</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-2-1893</u>
9. AGE (In years last birthday) <u>64</u>		FUNDER YEAR Months Days <u>8 8</u>	IF UNDER 24 HRS. Hours Min. <u>8</u>
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>Farm</u>	11. BIRTHPLACE (City and state or country) <u>Deaatar County Iowa</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>George Stratton</u>	
13b. MOTHER'S MAIDEN NAME <u>Mary Morehead</u>		14. NAME OF HUSBAND OR WIFE <u>William R Bacon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>William R. Bacon Bethany Mo</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Congestive Heart Failure</u>			<u>12 months</u>
DUE TO (c) <u>Arteriosclerotic Heart Disease</u>			<u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Bilateral Pyelonephritis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>--</u>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. <u>--</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>8/10/57</u> to <u>9/10/57</u> and last saw her/him alive on <u>9/10/57</u> Death occurred at <u>6:20 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>William R. Bacon</u> D.O.,		22b. ADDRESS <u>Bethany, Missouri</u>	22c. DATE SIGNED <u>9/13/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-13-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Antioch</u>	23d. LOCATION (City, town, or county) (State) <u>Bethany Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Wm. R. Bacon Bethany Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>9-14-1957</u>	26. REGISTRAR'S SIGNATURE <u>Jella Mayer</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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(Licensed Embalmer's Statement on Reverse Side)

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 *M. H. Hoos*

Licensed Embalmer No. *3899*
P. O. Address *Beth Ann Mo*

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.