

Dept. Health,  
U. S. Public  
Health Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

44142  
STATE FILE NUMBER

FILED DEC 23 1957

Registration District No. 133 Primary Registration District No. 3022 Registrar's No. 20

041  
V. S. 300  
Rev. 1-57

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) <u>Bethany</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Bethany</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>at home Beckman St.</u>		Length of stay in 1b <u>20 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>Beckman St</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Russell</u> Middle <u>Marian</u> Last <u>Bain</u>			4. DATE OF DEATH Month <u>12</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>Male</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>10-14-1914</u>	9. AGE (In years last birthday) <u>43</u>	10. FUNERAL YEAR Months <u>2</u> Days <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile Co</u>	11. BIRTHPLACE (City and state or country) <u>Harrison County Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Walter Bain</u>		13b. MOTHER'S MAIDEN NAME <u>Bonnie Maude Brower</u>		14. NAME OF HUSBAND OR WIFE <u>Walter Bain</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>496-03-7847</u>	17. INFORMANT <u>Walter Bain</u> Address <u>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>Coronary occlusion</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Angina pectoris</u>					<u>3 yrs.</u>	
DUE TO (c) _____					PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>				
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)						
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____						
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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>6-15-48</u> to <u>Dec 13, 1957</u> and last saw him alive on <u>Dec 13, 1957</u> Death occurred at <u>Dec 15, 10:15 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>Marian Gearhart MD</u> (Degree or title)				22b. ADDRESS <u>Bethany Mo</u>		
22c. DATE SIGNED <u>12/17/57</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-17-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sharon Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Old Moral Mo</u>		
24. FUNERAL DIRECTOR <u>W.B. Shaw</u>		ADDRESS <u>Bethany Mo</u>	25. DATE RECD. BY LOCAL REG. <u>12-17-1957</u>	26. REGISTRAR'S SIGNATURE <u>Jella Macey</u>		

securing the medical certification in the specific manner required by 193.140 MoRS 1949.  
 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.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

547  
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(Licensed Embalmer's Statement on Reverse Side)

MAY 23 1958

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 B J Isaac* .....

Licensed Embalmer No. *3899* .....

P. O. Address *Bethany, 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.