

Health, Welfare, Public Service, 300, 1-56, 4, 3000, 1-56, 4, USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE, Doctor, Colander, etc. must use only standard nomenclature in item 10. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

FILED MAR 31 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-012808

STATE FILE NUMBER

Registration District No. 324 Primary Registration District No. 30720 Registrar's No. 520

1. PLACE OF DEATH a. COUNTY <u>Saline</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u> <u>6970</u> Inside Limits			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>R.R. Slater, Missouri</u>		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Buford Rooming</u>			Length of stay in lb <u>2 years</u>	d. STREET ADDRESS (If outside, give location) <u>R.R. 1 Slater</u>			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Hattie</u> Middle <u>Sylvia</u> Last <u>Bausily</u>				4. DATE OF DEATH Month <u>March</u> Day <u>24th</u> Year <u>58</u>			
5. SEX <u>Female</u> <u>3</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <u>2</u> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 5, 1883</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>19</u>	IF UNDER 24 HRS. Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Saline, Missouri</u> <u>0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Bausily</u>				14. MOTHER'S MAIDEN NAME <u>Mary Grant</u>			
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 Address <u>Mr. Lacy Bausily, Marshall, Missouri</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>Broncho-pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Don't know</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						<u>491X</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						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 _____ a. m. _____ p. m. _____			<u>2</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		COUNTRY STATE	
21. I attended the deceased from <u>3/22/58</u> to <u>3/24/58</u> and last saw her alive on <u>3/24/58</u> Death occurred at _____ pm on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Waile H. Madison, M.D.</u>				22b. ADDRESS <u>Marshall, Mo. 154 W. Marion St.</u>		22c. DATE SIGNED <u>3/27/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3/28 /58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mt. Moriah Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Slater, Missouri</u>		
24. FUNERAL DIRECTOR <u>Green Funeral Home, Marshall, Mo.</u>			ADDRESS <u>3-27-58</u>		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE <u>Cecil G. Read</u>

(Licensed Embolmer's Statement on Reverse Side)

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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.....

Licensed Embalmer No. 4.

P. O. Address Wash

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.