

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-022052

STATE FILE NUMBER

FILED JUN 17 1959

Registration District No. 383

Primary Registration District No. 5655

Registrar's No. 65

300  
1-57

Locator, 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

1. PLACE OF DEATH a. COUNTY <b>Lawrence</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Mt. Vernon</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Springfield</b> <sup>0396</sup>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. State Sanatorium</b>		Length of stay in lb <b>5 days</b>	d. STREET ADDRESS (If outside, give location) <b>1100 W. Atlantic</b>
3. NAME OF DECEASED (Type or print) First <b>Olive</b> Middle <b>Houston</b> Last <b>Baugh</b>			4. DATE OF DEATH Month <b>May</b> Day <b>31</b> Year <b>1959</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 9, 1887</b>
9. AGE (In years last birthday) <b>71</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Mississippi</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Unknown</b>	
13b. MOTHER'S MAIDEN NAME <b>Mary E. Houston</b>		14. NAME OF HUSBAND OR WIFE <b>R. H. Baugh</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>0-428-40-5100A</b>	
17. INFORMANT <b>San. records, Mo. State San., Mt. Vernon, Mo.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Miliary Pulmonary tuberculosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Papillary adenocarcinoma of rectum</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <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.) <b>26</b>	
20f. CITY, TOWN, OR LOCATION <b>Springfield, Mo.</b>		COUNTY STATE	
21. I attended the deceased from <b>May 27, 1959</b> to <b>May 31, 1959</b> and last saw her <sup>her</sup> <del>him</del> alive on <b>May 31, 1959</b> Death occurred at <b>1:40 a.m.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>C. Hellweg M.D.</b>		22b. ADDRESS <b>Mt. Vernon, Mo.</b>	
22c. DATE SIGNED <b>6-2-59</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>5-31-59</b>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <b>Springfield, Mo.</b>	
24. FUNERAL DIRECTOR <b>Rex Rainey Funeral Home, Springfield, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>6-2-59</b>	
26. REGISTRAR'S SIGNATURE <b>Cecil Hendrick</b>			

MEDICAL CERTIFICATION

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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 ..... *[Handwritten Signature]*

Licensed Embalmer No. *5312*

P. O. Address *[Handwritten Address]*

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.