

FEDERAL BUREAU OF INVESTIGATION
FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS MAY 24 1960

=60-020193

Registration District No. 236 Primary Registration District No. 4352 Registrar's No. 30

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Morgan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Morgan</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Versailles</u>		Length of stay in 1b <u>Lifetime</u>		c. CITY OR TOWN <u>Versailles</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>Cann Clinic</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>U.S. Navy</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Terri</u> Middle <u>Gay</u> Last <u>Bauer</u>				4. DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Can.</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>5-15-60</u>	9. AGE (last birthday)	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>	IF UNDER 24 HR Hours <u>1</u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Versailles, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Wm. Bauer</u>			13b. MOTHER'S MAIDEN NAME <u>Barbara Humphrey</u>			14. NAME OF HUSBAND OR WIFE <u>Never Married</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>Wm Bauer Versailles, 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>Mucinous Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Prematurity</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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. _____	Month _____	Day _____	Year _____				
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>5-15-60</u> to <u>5-16-60</u> and last saw ^{him} _{her} alive on <u>5-16-60</u> Death occurred at <u>7 p.m. 5-16-60</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Ray T. E. M.D.</u>				22b. ADDRESS <u>Versailles, Mo.</u>		22c. DATE SIGNED <u>5-21-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>May 17, 60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Versailles Cemetery</u>		23d. LOCATION (City, town, or county) <u>Versailles, Missouri</u>		(State)	
24. FUNERAL DIRECTOR ADDRESS <u>Kidwell Funeral Home Versailles, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>5-23-60</u>		26. REGISTRAR'S SIGNATURE <u>J. Washburn</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Raymond C. Foster

Licensed Embalmer No. 4626

P. O. Address Versailles

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.