

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DR WAKEMAN 61-013281

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 128 Primary Registration District No. 200 Registrar's No. 254

FILED APR 17 1961

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		c. CITY OR TOWN SPRINGFIELD	
Length of stay in lb LIFE		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BURGE HOSPITAL		d. STREET ADDRESS (If outside, give location) 1353 NO. BROAD	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last JAMES LEROY BACON SR.			4. DATE OF DEATH Month Day Year APRIL 10 1961			
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/4/1918	9. AGE (last birthday) 42	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN BAKERY CO.		10b. KIND OF BUSINESS OR INDUSTRY HOLSUM BREAD CO.		11. BIRTHPLACE (City and state or country) SPRINGFIELD, MO.		12. CITIZEN OF WHAT COUNTRY U. S. A.
13a. FATHER'S NAME JAMES M. BACON		13b. MOTHER'S MAIDEN NAME MILDRED GRACE SMITH		14. NAME OF HUSBAND OR WIFE EVA BACON		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES W. W. # 2		17. INFORMANT Address MRS EVA BACON, SPRINGFIELD, MO	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <i>Acute Yellow Atrophy (Liver)</i>		1 week	
DUE TO (b) <i>Viral Hepatitis Acute</i>		2 weeks	
DUE TO (c)			

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		
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 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
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21. I attended the deceased from *Apr 1, '61* to *Apr 10, '61* and last saw her alive on *4-9-61*  
Death occurred at *3* A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>J. N. Wakeman M.D.</i>	(Degree or title)	22b. ADDRESS <i>Springfield Mo</i>	22c. DATE SIGNED <i>4-10-61</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 4/12/61	23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEMETERY	23d. LOCATION (City, town, or county) SPRINGFIELD, MO.	(State)
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24. FUNERAL DIRECTOR HERMAN LOHMEYER	ADDRESS SPRINGFIELD, MO	25. DATE RECD. BY LOCAL REG. 4-11-61	26. REGISTRAR'S SIGNATURE <i>Effie B. Meeter</i>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

APR 19 1961

**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 *PH McCann*

Licensed Embalmer No. 2727

P. O. Address *Spokane*

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.