

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-024292

STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 186

FILED AUG 14 1961

1. PLACE OF DEATH a. COUNTY <b>Callaway</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Callaway</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fulton</b>		c. CITY OR TOWN <b>Holt Summit</b>	
Length of stay in 1b <b>1 week</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Callaway Memorial Hosp</b>		d. STREET ADDRESS (If outside, give location) <b>R F D</b>	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last <b>Calhoun H Baysinger</b>			4. DATE OF DEATH Month Day Year <b>Aug 5 1961</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-12-1880</b>	9. AGE (last birthday) <b>81</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (City and state or country) <b>Callaway Co. Mo</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>John Baysinger</b>		13b. MOTHER'S MAIDEN NAME <b>Sahra Wolf</b>	
14. NAME OF HUSBAND OR WIFE <b>Lizzie Feeburt</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>None</b>	
17. INFORMANT <b>Mrs Mary Fleming Holt Summit 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>Cardiac Decompensation</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
DUE TO (b) <b>Myocardial Regeneration</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>Arricular Fibrillation</b>		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 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 8-31-61 to Death and last saw her/him alive on 8-4-61  
Death occurred at 5:00 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>John Brown MD</b>		22b. ADDRESS <b>Fulton Mo</b>		22c. DATE SIGNED <b>8-5-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8-6-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Union Hill Cemetery</b>	23d. LOCATION (City, town, or county) <b>Holt Summit Mo</b>	
24. FUNERAL DIRECTOR <b>LeRoy Claypool New Bloomfield</b>		25. DATE RECD. BY LOCAL REG. <b>Aug. 7-1961</b>		26. REGISTRAR'S SIGNATURE <b>Maretha Lawrence</b>

DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
ITEM NO. SHOULD READ

**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 LeRoy Claypool

Licensed Embalmer No. 4412

P. O. Address New Bloomfield,

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.