

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

67 0039185

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 248

FILED OCT 24 1967

1. PLACE OF DEATH a. COUNTY <u>Henry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Clair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Clinton</u>		c. CITY OR TOWN <u>Collins</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Clinton General Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>5 Mi. NE of Collins</u>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Jesse</u> Last <u>Baumgarden</u>			4. DATE OF DEATH Month <u>10</u> Day <u>17</u> Year <u>1967</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-21-1878</u>	9. AGE (last birthday) <u>89</u>	10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>		11. BIRTHPLACE (City and state or country) <u>St. Clair County U.S.A.</u>	
13a. FATHER'S NAME <u>Jacob Baumgarden</u>		13b. MOTHER'S MAIDEN NAME <u>Savilla Walker</u>		14. NAME OF HUSBAND OR WIFE <u>Lula Baumgarden</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>no</u>		17. INFORMANT Address <u>Lula Baumgarden Collins, 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>Urinary tract Cancer and Obstruction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>28 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u>		<u>2 mo</u>
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 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 <u>8</u> a.m. <u>26</u> Month, Day, Year <u>10-17-67</u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 8-26-67 to 10-17-67 and last saw ^{her}him alive on 10-17-67
Death occurred at 10:20 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>W.D. Bradburn, M.D.</u>	(Degree or title)	22b. ADDRESS <u>Clinton, Mo.</u>	22c. DATE SIGNED <u>10-17-67</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-20-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Kings Prairie Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Clair County Mo.</u>
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24. FUNERAL DIRECTOR <u>Goodrich Funeral Home Osceola, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Oct 19, 1967</u>	26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

DATE AMENDED

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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

Paul Trivette

Licensed Embalmer No.

3940

P. O. Address

Osceola, Mo

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.

Permit Obtained 10-19-61 1965