

RECUMAY 13 1938

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

15539
Do not use this space.

1. PLACE OF DEATH
 (a) County Sheepers Registration District No. 677
 (b) Township _____ Primary Registration District No. 4403
 (c) City Rolla (d) Street No. Rolla Hospital Registered No. 70
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 2. PRINT FULL NAME Columbus Eugene Baum 650
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ethel Baum
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 18, 1891
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 47 3 11
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Supr of Schools
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) James Prairie Mo
 FATHER 13. NAME Geo. W. Baum
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marion Mo
 MOTHER 15. MAIDEN NAME Elizabeth Hutchins
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.
 17. INFORMANT Miss Agnes Baum
 (ADDRESS) Mr. Vernon Lee
 18. BURIAL CREMATION, OR REMOVAL PLACE Broadway DATE May 1 1938
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. Lee Allen
Rolla Mo
 20. FILED May 1 1938 J. F. Oyer
 (Address) Rolla Mo
 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 29 1938
 22. I HEREBY CERTIFY, That I attended deceased from Apr 18 - 1938 to Apr 29 - 1938
 I last saw him alive on Apr 29 - 1938 Death is said to have occurred on the date stated above, at 8:30 p.m.
 The principal cause of death and related causes of importance were as follows:
Typhoid Fever
 Date of onset _____
 Other contributory causes of importance: Malignancy of abdominal viscera
 Name of operation no Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? yes
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) R. E. Bremer M. D.
 (Address) Rolla Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

MAR 19 1945

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 _____

Registered Apprentice No. _____, working under my personal supervision.

Signed S. C. [Signature]

Licensed Embalmer No. 3397

P. O. Address Rolla 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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

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Do not use this space.

1. PLACE OF DEATH

(a) County Phelps Registration District No. 677

(b) Township Ralls Primary Registration District No. 4403

(c) City Ralls (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Columbus Lycourgen Crum

(a) Residence, No. _____ St. (If nonresident, give city or town and State)

(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>47</u>	<u>3</u>	<u>11</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19 _____

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____ 19 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 29 1938

22. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

SUPPLEMENTARY

Supposed Scurvy

Date of onset _____

Other contributory causes of importance:

Malignancy of abdominal viscera

mesenteric Primary

Name of operation _____ Date of _____

What test confirmed diagnosis? REB Was there an autopsy? 4/27/38

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____ 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) R. E. Brewer, M. D.

(Address) Newburg, mo

Local Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

