

FILED APR 28 1944

Registration District No. **128**

Primary Registration District No. **2000**

Registrar's No. **316**

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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Greene**

(b) City or town **Springfield Mo.**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution **St. John Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **8 weeks**
(Specify whether years, months or days)

In this community **8 weeks**

3. (a) PRINT FULL NAME **Bessie Bain**

3. (b) If veteran, name war **None**

3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White**

6. (a) Name of husband or wife **Howard Bain**

6. (b) Name of husband or wife **Howard Bain**

6. (c) Age of husband or wife if alive **65** years

7. Birth date of deceased **June 22, 1889**
(Month) (Day) (Year)

8. AGE: Years **54** Months **9** Days **16**
If less than one day hr. min.

9. Birthplace **Christian Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **House Wife**

11. Industry or business

MOTHER FATHER

12. Name **Tom A. Keeton**

13. Birthplace **Unk. Arkansas**
(City, town, or county) (State or foreign country)

14. Maiden name **Martha Williams**

15. Birthplace **Unk. Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Howard Bain**

(b) Address **Sparta Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **April 10, 1944**
(Month) (Day) (Year)

(c) Place: burial or cremation **Selmore Cemetery**

18. (a) Signature of funeral director **T. B. Chabbin**

(b) Address **Spark Mo.**

19. (a) **4-14-44** (b) **Dr. W. Handley**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Christian**

(c) City or town **Sparta Mo. 22**
(If outside city or town limits, write "RURAL")

(d) Street No. **Home**
(If rural, give location)

(e) Citizen of foreign country? **No.** (Yes or No)

If yes, name country **1**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **8** of year **1944** hour **12** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **2-29-44**, 19... to **4-8-44**, 19... that I last saw him alive on **4-8-44**, 19... and that death occurred on the date and hour stated above.

Immediate cause of death **Osteomyelitis of Left Mandible**
Agranulocytosis

Due to...
Due to...

Other conditions (Include pregnancy within 3 months of death)

Major findings: **154 P**
Of operations...
Of autopsy...

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature **Paul D. Morgan M.D.** (M. D. or other) _____
Address **Springfield, Mo.** Date signed **7-7-44**

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 T. B. Chaffin
Licensed Embalmer No. 2192
P. O. Address Ozark, 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, fact should be so stated above.

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