

No. 2  
Bureau of the Census  
5-17-39  
X-3587

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED AUG 7 1947

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 24524

Registrar's No. 785

Registration District No. 257

Primary Registration District No. 3228

1. PLACE OF DEATH:

(a) County Jasper  
(b) City or town Carthage  
(c) Name of hospital or institution: Nurseing Home  
(d) Length of stay: In hospital or institution 50 yrs.  
In this community 50 yrs.

3. (a) PRINT FULL NAME

Edwin K. Bair

(b) If veteran, name war

(c) Social Security No.

4. Sex Male, 5. Color or race White, 6. (a) Single, widowed, married: Widowed

6. (b) Name of husband or wife, 6. (c) Age of husband or wife if alive

7. Birth date of deceased August 1861

8. AGE: Years 85, Months II, Days I6

9. Birthplace Macon County, Ill.

10. Usual occupation Retired Railroad Mo. Pac

11. Industry or business

MOTHER FATHER

12. Name Isaac Bair

13. Birthplace No Data

14. Maiden name Katherine Moore

15. Birthplace No Data

16. (a) Informant Neice, (b) Address Picher Okla.

17. (a) Burial, (b) Date thereof 7/29-47

(c) Place: burial or cremation Webb City Cem.

18. (a) Signature of funeral director Hedge-Lewis Funeral Home

(b) Address Webb City Mo.

9. (a) 7-30-47, (b) P. S. [Signature]

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County Jasper, (c) City or town Webb City, (d) Street No., (e) Citizen of foreign country? No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July, day 25, year 1947, hour 10, minute 30 PM.

21. I hereby certify that I attended the deceased from June 10, 1947, to July 20, 1947, that I last saw him alive on July 30, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma, malignent.

Due to

Due to

Other conditions: (Include pregnancy within 3 months of death)

Major findings: 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?

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

(Specify type of place) (e) Means of injury

23. Signature E. E. [Signature] (M. D. or other)

Address [Signature] Date signed 7-28-47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

47-8-609

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.....

*Leonard J. Lewis Jr.*....., Registered Apprentice No. *46*  
working under my personal supervision.

Signed..... *E W Hedge*  
Licensed Embalmer No. *2859*  
P. O. Address..... *Webb City, 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.

Registration District No. 157

Primary Registration District No. 3028

1. PLACE OF DEATH:

(a) County Jasper  
(b) City or town Carthage  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME

Edwin K. Bauer

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE:

Years 85

Months 11

Days \_\_\_\_\_

If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (Burial, cremation, or removal)

(b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (Date received local registrar)

(b) \_\_\_\_\_ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATE

20. DATE OF DEATH: Month \_\_\_\_\_ Year 194 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Cancer affecting left eye and throat

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

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) (e) Means of injury \_\_\_\_\_

23. Signature E. E. Boats (M. D. or other)  
J. P. Boats  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

24524