

No. 2
-12-45
-17-39
I X47070

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40899**
Registrar's No. **1482**

FILED DEC 29 1947

Registration District No. **22**

Primary Registration District No. **1000**

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

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
State Hospital No 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 mo 3 day
(Specify whether
In this community 3 mo 3 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Charles Bacon

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex male 5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Ledis Lee Bacon
6. (c) Age of husband or wife if alive 74 years
7. Birth date of deceased XXXXXX Dec 1, 1868
(Month) (Day) (Year)

8. AGE: Years 79 Months 0 Days 14
If less than one day hr. min.

9. Birthplace not given Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business

MOTHER FATHER { 12. Name Samuel M Bacon
13. Birthplace not given unknown
(City, town, or county) (State or foreign country)
14. Maiden name Martha Gibbs
15. Birthplace not given unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Leticia Bacon
(b) Address Excelsior Spgs mo

17. (a) Removal (b) Date thereof 12-15-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crown Hill

18. (a) Signature of funeral director Blaise Sarchal

(b) Address Excelsior Spgs mo

19. (a) 12-18-47 (b) G. G. Jenkins
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 15
year 1947 hour 3 minute 35 P M.
21. I hereby certify that I attended the deceased from Dec 2
2, 1947, to Dec 15, 1947,
that I last saw him alive on Dec 15, 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death cerebral hemorrhage

Due to arterio sclerosis - by pertension

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? (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 Forrest Thomas (M. D. certifier)
Address St Joseph Mo Date signed 12/15 47

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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 Bland Michael

Licensed Embalmer No. 2751

P. O. Address Excelsior Springs

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..