

FILED MAR 7 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5398
State File No. _____
Registrar's No. 765

BIRTH NO. _____ REG. DIST. NO. 283 PRIMARY REG. DIST. NO. 5655

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

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Lawrence</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Wame</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Mt. Vernon</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Patterson</u> | |
| c. LENGTH OF STAY (in this place) <u>1</u> <u>549</u> days | | d. STREET ADDRESS (If rural, give location) <u>1</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri State Sanatorium</u> | | | |

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|---|--|---|---|---|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Martin</u> b. (Middle) <u>Davis</u> c. (Last) <u>Bacon</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Feb.</u> <u>13</u> <u>1949</u> | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | |
| 8. DATE OF BIRTH <u>9-18-81</u> | | 9. AGE (In years last birthday) <u>67</u> | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u> | | 10b. KIND OF BUSINESS/OR INDUSTRY <u>Farm</u> | | 11. BIRTHPLACE (State or foreign country) <u>Marine, Illinois</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u> | | | | | |

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|---------------------------------------|--|---|--|--|--|
| 13a. FATHER'S NAME <u>Asapy Bacon</u> | | 13b. MOTHER'S MAIDEN NAME <u>Neoma Brooks</u> | | 14. NAME OF HUSBAND OR WIFE <u>Clara Ellen Bacon</u> | |
|---------------------------------------|--|---|--|--|--|

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|--|--|--|--|--|--|
| 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>377-24-0439</u> | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>E. McMichael, Record Clerk, Mo. State Sanatorium, Mt. Vernon, Mo.</u> | |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i> | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Far Advanced Pulmonary Tuberculosis</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Hypertension</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Abt 3 yrs.</u> | |
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|------------------------|--|----------------------------------|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
|------------------------|--|----------------------------------|--|--|--|--|--|

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|---|--|--|--|---|--|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |

22. I hereby certify that I attended the deceased from April 26, 1947, to Feb. 13, 1949, that I last saw the deceased alive on Feb. 13, 1949, and that death occurred at 11:58a.m., from the causes and on the date stated above.

| | | | | | |
|--|--|--------------------------------------|--|---------------------------------|--|
| 23a. SIGNATURE (Degree or title) <u>C. E. Halloway M. D.</u> | | 23b. ADDRESS <u>Mount Vernon, Mo</u> | | 23c. DATE SIGNED <u>2-13-49</u> | |
|--|--|--------------------------------------|--|---------------------------------|--|

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|--|--|--------------------------|--|---|--|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 24b. DATE <u>2-13-49</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Patterson</u> | | 24d. LOCATION (City, town, or county) (State) <u>Mo</u> | |
|--|--|--------------------------|--|---|--|---|--|

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|---|--|---|--|---|--|
| DATE REC'D BY LOCAL REG. <u>2-14-49</u> | | REGISTRAR'S SIGNATURE <u>Cecil R. Dickson</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Max L. Jorsett Mt Vernon, Mo.</u> | |
|---|--|---|--|---|--|

RECEIVED

District Health Officer No. 6

District File Number 349-236

Date Filed 3-4-49

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.

Signed Max L. Tinsell

Signed _____
Student Embalmer

Licensed Embalmer No. 4252

P. O. Address Mt Vernon, 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.