

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20710

State File No.

FILED JUL 6 - 1951

BIRTH NO. 45999-51 REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 3040 Registrar's No. 81

1. PLACE OF DEATH a. COUNTY <u>Linnigston</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Linnigston</u>	
b. CITY OR TOWN <u>Chillicothe</u>	c. LENGTH OF STAY (In this place) <u>10 hrs.</u>	c. CITY OR TOWN <u>Chillicothe</u> <u>1592</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Chillicothe Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>✓</u>	

3. NAME OF DECEASED a. (First) <u>Mary</u> b. (Middle) <u>Ann</u> c. (Last) <u>Bauer</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>June 20, 1951</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 19, 1951</u>		9. AGE (In years if under 1 year; last birthday) <u>10</u> Months <u>10</u> Days <u>10</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>	11. BIRTHPLACE (State or foreign country) <u>Chillicothe, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Robert Bauer</u>	13b. MOTHER'S MAIDEN NAME <u>Jane Meek</u>	14. NAME OF HUSBAND OR WIFE <u>✓</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>✓</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Robert Bauer - Cameron, Mo.</u>	ADDRESS <u>✓</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Premature birth 7 mo. gestation</u>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

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) <u>Chillicothe Lin. MO.</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR
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22. I hereby certify that I attended the deceased from 6-19-1951 to 6-20-1951 that I last saw the deceased alive on 6-19-1951, and that death occurred at 7 A. m., from the causes and on the date stated above.

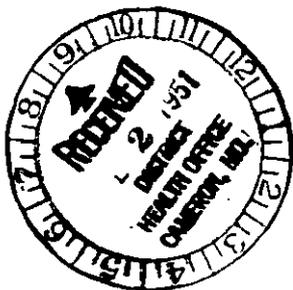
23a. SIGNATURE <u>Wm Dowell, M.D.</u> (Degree or title)	23b. ADDRESS <u>Chillicothe Mo 6-21-51</u>	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>6-21-51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Catholic</u>	24d. LOCATION (City, town, or county) (State) <u>Chillicothe Mo.</u>
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DATE REC'D BY LOCAL REG. <u>6-21-51</u>	REGISTRAR'S SIGNATURE <u>Frances B. O'Neill</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Donald Gordon</u> ADDRESS <u>Chillicothe Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 _____

working under my personal supervision.

Student Embalmer No.

Signed Donald F. Gordon

Signed.....
Student Embalmer

Licensed Embalmer No. 4191

P. O. Address Phillipsite, Md.

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.