Health, Welfare Public Service

300 1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

31632
STATE FILE NUMBER

FILED OCT 14 1957

Registration District No. 141 Primary Registration District No. 5551 Registrar's No. 21

1. PLACE OF DEATH
a. COUNTY Newton
b. CITY OR TOWN West Plains — Inside Limits Yes ☐ No ☑
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Nuway 160 S. — Length of stay in Hospital: Nun

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Ozark
c. CITY OR TOWN Bakersfield — Inside Limits Yes ☐ No ☑
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First: Gary Middle: Allan Last: Bales

4. DATE OF DEATH Month: 10 Day: 4 Year: 1957

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-4-1957
9. AGE (In years last birthday): IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS. Hours: 1 Min.: 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Bakersfield Mo
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: LaRoe Bales
13b. MOTHER'S MAIDEN NAME: Margaret Lozros
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Leone Bales Address: Bakersfield Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) asphyxia neonatorum — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Polyhydramnios
DUE TO (c) Short umbilical cord
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 7610

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 10-4-57, to 10-4-57 and last saw her/him alive on 10-4-57
Death occurred at 9:00 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE B.B. Storey (Degree or title) D.O.
22b. ADDRESS Bakersfield Mo
22c. DATE SIGNED 10-5-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Bu
23b. DATE 10-5-57
23c. NAME OF CEMETERY OR CREMATORY Bakersfield
23d. LOCATION (City, town, or county) Bakersfield (State) Mo

24. FUNERAL DIRECTOR Robert McWilliams ADDRESS Mo
25. DATE RECD. BY LOCAL REG. 10-11-57
26. REGISTRAR'S SIGNATURE Beatrice Cook

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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.

Student .....
Signature of Student Embalmer

Signed .....

Licensed Embalmer No. .....

P. O. Address .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.