MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Dade

Township ______ Registration District No. 286 File No. 34128

or Village ______ Primary Registration District No. 4143 Registered No. 11

or City Everton Mo (NO. ______ St.; ______ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Isom P. Baker

PERSONAL AND STATISTICAL PARTICULARS		
SEX: Male	COLOR OR RACE: White	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): married

DATE OF BIRTH: June (Month) 30 (Day), 1848 (Year)

AGE: 63 yrs. 3 mos. 20 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): 102

BIRTHPLACE (City or town, State or foreign country): Miss

PARENTS
NAME OF FATHER: Geo V Baker
BIRTHPLACE OF FATHER (City or town, State or foreign country): Miss.
MAIDEN NAME OF MOTHER: Hastings
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Miss

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo V Baker
(ADDRESS) Lockwood Mo

Filed Oct 21 1911 G. M. Box REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Oct (Month) 20 (Day), 1911 (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 20, 1911, to Oct 18, 1911, that I last saw him alive on Oct 18, 1911, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:
Tuberculosis Pulmonalis
23A
(Duration) ___ yrs. 6 mos. ___ ds.

Contributory (SECONDARY) ______
(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) D. W. R. Riley M. D.
Oct 21, 1911 (Address) Everton

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.
Where was disease contracted if not at place of death? ______
Former or usual residence ______

PLACE OF BURIAL OR REMOVAL: Smith Dade Co. DATE OF BURIAL: 10/22 1911

UNDERTAKER: J. R. Mason ADDRESS: Everton Mo

Statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... or Village..... or City .....

Registration District No.....

Primary Registration District No.....

File No.....

Registered No.....

(NO. ..... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., 1..... (Month) (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

OCCUPATION

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE (City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER (City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 191..... (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191....., that I last saw h..... alive on ....., 191....., and that, death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....ds.

Contributory (Secondary).....

.....(Duration).....yrs.....mos.....ds.

(Signed)..... M. D.

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191.....
UNDERTAKER	**ADDRESS**

CAUSE OF DEATH [illegible]