

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County Pettis

Township _____

or

Village _____

or

City Sedalia (NO. 1629 S. Prospect St. 4 Ward)

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 668

File No. _____

15473

Primary Registration District No. 3032

Registered No. 123

FULL NAME Charles M. Baker

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

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE Married
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH Dec. 14, 1879
(Month) (Day) (Year)

AGE 36 yrs. 4 mos. 8 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) G. R. Shoppe

BIRTHPLACE
(City or town, State or foreign country) Indiana

PARENTS

NAME OF FATHER C. J. Baker

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

MAIDEN NAME OF MOTHER Mary Butterfield

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jno. McLaughlin

(ADDRESS) Sedalia, Mo.

Filed April 22, 1916 M. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 22, 1916
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from April 12, 1916, to Apr 18, 1916, that I last saw him alive on Apr 18, 1916, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Brain tumor.

55D

Contributory
(SECONDARY)

(Duration) ____ yrs. ____ mos. ____ ds.
(Signed) Edw. A. Albers, M. D.
April 22, 1916 (Address) Sedalia, Mo.

*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 ____ 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

Berman, Mo. Apr. 23, 1916

UNDERTAKER

ADDRESS

McLaughlin Bros. Sedalia, Mo.

PLACE OF DEATH

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

County _____

Township _____ or _____

Village _____ or _____

City _____ (NO. _____)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered 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 (If write the word)
DATE OF BIRTH	(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) _____

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 _____ (Month) _____ (Day) _____, 191____ (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) _____ 191____ (Address) _____ M. D.

* 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. 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
UNDERTAKER	ADDRESS

WRITE PLAINLY, WITH INK—THIS IS A PERMANENT RECORD

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