

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.

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

 PLACE OF DEATH
County Pettis

Township _____

or

Village _____

or

 City Sedalia

 Registration District No. 668

 Primary Registration District No. 3032

 File No. 18789

 Registered No. 139

St.: _____ Ward _____

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

 FULL NAME William S Baker

PERSONAL AND STATISTICAL PARTICULARS

 SEX M

 COLOR OR RACE W

 SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word) widower

DATE OF BIRTH

Aug 12, 1834
(Month) (Day) (Year)

AGE

81 yrs. 9 mos. 18 ds.

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

OCCUPATION

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

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

BIRTHPLACE

 (City or town, State or foreign country) Kenn.

 NAME OF FATHER Andrew Baker

BIRTHPLACE OF FATHER

 (City or town, State or foreign country) Un known

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER

 (City or town, State or foreign country) 11

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

 (Informant) Douglas Lane

 (ADDRESS) Sedalia Mo

 Filed May 31, 1916

 REGISTRAR A. B. Long

MEDICAL CERTIFICATE OF DEATH

 DATE OF DEATH May 30, 1916

(Month)

(Day)

(Year)

 I HEREBY CERTIFY, that I attended deceased from Apr 11, 1916, to May 30, 1916, that I last saw him alive on May 30, 1916, and that death occurred, on the date stated above, at 7:55 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary edema.
131
320
1113 (Duration) yrs. mos. ds.

 Contributory Paralysis, White
Neurotic degeneration yrs. mos. ds.

 (Signed) E. R. Shaker M. D.

May 31, 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 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

Sedalia Mo
June 1, 1916

UNDERTAKER

ADDRESS

McLaughlin

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
hospital or institution,
give its NAME and
of street and number)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (If write the word)
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DATE OF BIRTH

_____, _____, 19____ (Month) _____ (Day) _____ (Year)

AGE

_____, _____, _____ 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 _____

19____

REGISTRAR

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____, _____, 19____ (Month) _____ (Day) _____ (Year)

I HEREBY CERTIFY, that I attended deceased

_____, 19____, to _____, 19____, that I last saw him alive on _____, 19____,

and that death occurred, on the date stated above, at _____

The CAUSE OF DEATH was as follows:

(Duration) _____ yrs. _____ mos.

Contributory

(SECONDARY)

(Duration) _____ yrs. _____ mos.

(Signed) _____

M

(Address) _____, 19____

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, RECENT RESIDENTS)

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

Where was disease contracted if not at place of death?

Former or usual residence. _____

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as probably such, if impossible to determine definitely.