LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

9527

1 PLACE OF DEATH

County Knox

Township Wyatte
or
Village
or
City (NO. St.; Ward)

Registration District No. 444 File No.

Primary Registration District No. 9403 Registered No. 4

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

2 FULL NAME Rebecca Adaline Baker

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: November 25 (Month) (Day) 1854 (Year)

7 AGE: 63 yrs. 3 mos. 9 ds.

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

8 OCCUPATION
(a) Trade, profession, or particular kind of work:
(b) General nature of industry business, or establishment in which employed (or employer): Home Keeper

9 BIRTHPLACE (City or town, State or foreign country): Missouri

PARENTS

10 NAME OF FATHER: Philip Bieler

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

12 MAIDEN NAME OF MOTHER: Melinda Rockel

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Fred Baker
(Address): Knox City Mo.

15 Filed March 3 1918 J R Hollcraft Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March (Month) 3 (Day) 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Feb 27 1918, to March 3 1918, that I last saw her alive on March 2 1918, and that death occurred, on the date stated above, at 5-9 m.

The CAUSE OF DEATH* was as follows:
Organic Heart Disease
95 B
(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) J R Hollcraft M. D.
March 3 1918 (Address) J R Hollcraft

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

18 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

19 PLACE OF BURIAL OR REMOVAL: Knox City Mo. DATE OF BURIAL: March 5 1918

20 UNDERTAKER: Mc Keyes & Son ADDRESS: Edina Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

1 PLACE OF DEATH

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

County .....

Township..... Registration District No..... File No.....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City..... (NO....., ...St.;.....Ward)

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

2FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

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

7 AGE

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

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

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

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

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

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address).....

15

Filed....., 191....., ...egistrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

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

17 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.

18 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.....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS

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.

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