

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 Union
Township Chautau
or
Village
or
City _____ (NO. _____ St. _____ Ward _____)

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

Registration District No. 529 File No. 9722
Primary Registration District No. 2705 Registered No. 62

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

FULL NAME John T Baker

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH May 1st, 1 _____
(Month) (Day) (Year)

AGE 63 yrs. 11 mos. 11 ds. If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Farm
(b) General nature of industry, business, or establishment in which employed (or employer) _____

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

PARENTS

NAME OF FATHER Johnson Baker
BIRTHPLACE OF FATHER (City or town, State or foreign country) Kt.
MAIDEN NAME OF MOTHER Jonissa Sporen
BIRTHPLACE OF MOTHER (City or town, State or foreign country) W. Va.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs John Baker
(ADDRESS) Berrie Mo.

Filed May 8, 1918 H. T. Farned
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 30, 1918
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from March 23, 1918, to March 29, 1918, that I last saw him alive on March 29, 1918, and that death occurred, on the date stated above, at 10 u.m.
The CAUSE OF DEATH* was as follows:

107 Broncho Pneumonia
(Duration) _____ yrs. _____ mos. 6 ds.

Contributory Muscles
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) H. E. Ralston M. D.
April 1, 1918 (Address) Keota 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 Powell Mansfield DATE OF BURIAL 3/31, 1918

UNDERTAKER Albert Skinner ADDRESS Maerom

PLACE OF DEATH

County.....

Township.....

or.....

Village.....

or.....

City.....

(NO.....)

Registration District No.....

Primary Registration District No.....

File 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 give the word)
DATE OF BIRTH		
(Month)....., 191.....		(Day)....., 191.....
AGE		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)

PARENTS

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

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

REGISTRAR

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH	1.....	(Month).....	(Day)....., 191.....
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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:

Contributory
(SECONDARY)

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

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

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

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

*State the Disease Causing Death, or, in deaths from Violent Cause, 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

191.....