

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

Do not use this space.

23173

1. PLACE OF DEATH

County.....

Registration District No. **701**

1003

Township.....

Primary Registration District No.

City *St. Louis* (No. *Barnes Hospital*)

File No.

Registered No. **6808**

St.

Ward)

2. FULL NAME *BAKER, SUSAN, L.*

(a) Residence. No. *814 CLARA AVE* St. *12* Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Sept 1 1888

7. AGE

38

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

10

27

8. OCCUPATION OF DECEASED

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

Stenographer

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Mexico Mo

10. NAME OF FATHER

James R Baker

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Missouri

12. MAIDEN NAME OF MOTHER

Susan Larimore

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Missouri

14.

INFORMANT (Address)

*H. L. Baker
814 Clara Ave*

15.

FILED

19

Mar 6 Starckoff

REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

7-28-1927

17.

I HEREBY CERTIFY, That I attended deceased from

7-9-1927, to *7-28-1927*

that I last saw h. e. r. alive on *7-28-1927*, and that death occurred, on the date stated above, at *3:25 P. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

malnutrition cause could not be determined no Organic trouble

CONTRIBUTORY (SECONDARY)

Pneumonia, terminal

Broncho

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

1000

DID AN OPERATION PRECEDE DEATH? *no* DATE OF

WAS THERE AN AUTOPSY? *yes*

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) *G. G. Neube*, M. D.

, 19 (Address) *Barnes Hosp*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Mexico Mo

7/30 1927

20. UNDERTAKER

ADDRESS

C. R. Lupton

4449 Olive

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.

STATEMENT RECORD

