

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

Do not use this space.

OCT 25 1927

26722

**1. PLACE OF DEATH**

County Carrroll Registration District No. 139  
 Township Hill Primary Registration District No. 5200  
 City (No. ....) St. .... Ward (....)

File No. ....  
 Registered No. 11

**2. FULL NAME**

Virgian Elizabeth Baker

(a) Residence. No. .... St. .... 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) Jan 20 1918

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ... hrs. or ... min.  
8 | 8 | 16

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Child  
 (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) Carrroll Co Mo

**10. NAME OF FATHER**

Lutie Baker

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) Carrroll Co Mo

**12. MAIDEN NAME OF MOTHER**

Virgian

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) Carrroll Co Mo

**14. INFORMANT**

Berline Baker  
 (Address) Regard Mo

**15. FILED**

9/17 1927 J.P. Edmondson  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/16 1927

17. I HEREBY CERTIFY, That I attended deceased from Sept 10, 1927 to Sept 16, 1927 that I last saw him alive on Sept 16, 1927, and that death occurred, on the date stated above, at 2:45 p.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Diffuse Peritonitis  
1218 (duration) yrs. mos. ds.  
129 CONTRIBUTORY (SECONDARY) Appendicitis (duration) yrs. mos. ds. 10

**18. WHERE WAS DISEASE CONTRIBUTORY**

117 B IF NOT AT PLACE OF DEATH .....

DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? no

**WHAT TEST CONFIRMED DIAGNOSIS**

(Signed) H.F. Cook M. D.  
9-16-1927 (Address) Carrallton Mo

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

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL**

Walton Mo

**DATE OF BURIAL**

9/18 1927

**20. UNDERTAKER**

E. A. Weir  
 ADDRESS Boyd Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. PHYSICIANS should state

