

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

Do not use this space.

40592

B. 74936

1. PLACE OF DEATH

County Jackson Registration District No. _____
 Township 1st Primary Registration District No. _____
 City J.C.Mo. (No. 4022 Brooklyn, Mo., St. _____ Ward)

2. FULL NAME

William E. Baker
 (a) Residence, No. 4022 Brooklyn, St. 15 Ward. (If nonresident give city or town and State)
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 14, 1849

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
79 | 6 | 23

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Pattern maker
 (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) Pa

10. NAME OF FATHER Geo. Baker

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) No Record

12. MAIDEN NAME OF MOTHER No Record

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) No Record

14. INFORMANT Mrs. Pearl Thomas
 (Address) 4022 Brooklyn, Mo.

15. B-7 1928 M. M. Crowl
 Filed _____ REGISTRAR act

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/7 1928

17. Deputy Coroner
 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic myo carditis
121
935
 _____ (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) Chronic
interstitial nephritis
 _____ yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS autopsy

(Signed) Stanley M. Hall, M. D.
12-8, 1928 (Address) Deputy Coroner

*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 DATE OF BURIAL

Mt. Washington Dec 8-1928

20. UNDERTAKER ADDRESS

Mrs. C. L. Foster J.C.Mo.

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

K. 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.

