

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

Do not use this space.

2525

**1. PLACE OF DEATH**

County Mississippi Registration District No. 566 File No. \_\_\_\_\_  
 Township Waverly Primary Registration District No. 3030 Registered No. 17  
 City Charleston (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

William 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 70 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (circle the word) Widowed  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Low Baker  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 24 1849  
 7. AGE YEARS 79 MONTHS 6 DAYS 4 If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.  
 8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Farmer  
 (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)**

Unknown  
Joneses  
**10. NAME OF FATHER** Jacob Baker  
**11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)** Unknown  
**12. MAIDEN NAME OF MOTHER** Unknown  
**13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)** Unknown

14. INFORMANT X Charley Lloyd  
 (Address) X Charleston, Mo.

15. Jan 29 1929 Ed Jovan  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

2 **16. DATE OF DEATH (MONTH, DAY AND YEAR)** Jan. 28<sup>th</sup> 1929 5 A.M.  
**17.** I HEREBY CERTIFY, That I attended deceased from 1/19, 1929, to 1/28, 1929, that I last saw him/her alive on 1/28, 1929, and that death occurred, on the date stated above, at 5-a m.

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

Chronic Myocarditis  
 (duration) 2 yrs. mos. ds.  
**CONTRIBUTORY (SECONDARY)** Hypostatic Pneumonia  
 (duration) 2 yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH, \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH, \_\_\_\_\_ DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? \_\_\_\_\_  
 WHAT TEST CONFIRMED DIAGNOSIS \_\_\_\_\_  
 (Signed) W. S. Love, M. D.  
1/28, 1929 (Address) Charleston, 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 Oak Grove DATE OF BURIAL 1/30 1929  
 20. UNDERTAKER Laird Co. [Signature] ADDRESS Charleston

N. B.—Every item of information should be given in plain terms, so that it may be properly understood.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Mississippi Registration District No. 2-66 File No. ....  
 Township Wynona Primary Registration District No. 3030 Registered No. 17  
 City (No. ....) St. .... Ward)

**2. FULL NAME**

William 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 24 - 1849

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .... hrs. or .... min.  
49 | 6 | 7

**8. OCCUPATION OF DECEASED**

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

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

FILED ..... 19.....

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) JAN 28 1929

17. I HEREBY CERTIFY That I attended deceased from ..... 19..... 19.....  
 that I last saw him alive on ..... 19....., and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH WAS AS FOLLOWS:

Chronic Myocarditis  
Bencho Pneumonia  
 (duration) yrs. mos. ds.  
 CONTRIBUTORY (SECONDARY) Hypostatic Pneumonia  
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH DATE

WAS THERE AN AUTOPSY

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) ..... M. D.  
 , 19 (Address)

\*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

19

20. UNDERTAKER

ADDRESS

WRITE FULL NAME WITH SURNAME IN FULL THIS IS A PERMANENT RECORD  
 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. Error in statement of OCCUPATION is very common. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

90B

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