

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

Do not use this space.

31562
Mr Mitchell
File No. _____
Registered No. 280
St. _____ Ward _____

1. PLACE OF DEATH

County Butte
Township Gravie
City Sealed (No. _____)

Registration District No. 665
Primary Registration District No. 5890

2. FULL NAME

Joseph A Baker
(a) Residence, No. R 7 D # 6 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 22, 1889

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
70 10 5

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) Ind.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) unknown

14.

INFORMANT (Address) Mrs Joseph Baker
Sealed R 7 D # 6

15.

FILED 9-28-29

REGISTRAR J. S. Love

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 27, 1929

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____

that I last saw him alive on April 27, 1929 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

arterio sclerosis
Diabetes mellitus
(duration) 1 yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) J. S. Love M. D.

, 19____ (Address) Sealed R 7 D # 6

*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

Crown Hill

9/29/29

20. UNDERTAKER

ADDRESS

Sealed R 7 D # 6

Sealed R 7 D # 6

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.

80
130

