

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

Do not use this space.

37611

1. PLACE OF DEATH Union

County.....
Township..... Chilhowee
City..... (No.....)

Registration District No.....
Primary Registration District No..... 550

File No.....
Registered No.....
St..... Ward.....

2. FULL NAME Lizzie Lavinia Baker

(a) Residence, No. magnolia Mo. 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) married.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr. 29 - 1864

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
65 6 3

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House-wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Whallon
(STATE OR COUNTRY) Ohio

10. NAME OF FATHER W. W. Hall

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

12. MAIDEN NAME OF MOTHER Martha Lopez

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) L'Assac, Co. Ky.

14. INFORMANT (Address) Mrs Ruth Atkins.

15. FILED, 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 2, 1929

17. I HEREBY CERTIFY that I attended deceased from above date that I last saw her alive on Nov. 2, 1929 and that death occurred, on the date stated above, at 11:30 P. a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Apoplexy

3 hours (duration) yrs. mos. ds.
CONTRIBUTORY High blood pressure (SECONDARY) (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF..... none

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Characteristic Symptom
(Signed) R. L. Gille, M. D.
, 19..... (Address) Magnolia, 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 DATE OF BURIAL
Holder Cemetery Nov 5 1929

20. UNDERTAKER ADDRESS
J. N. Goodman Holder Mo.

25
9
12
2

THE UNIVERSITY OF CHICAGO

PHYSICS DEPARTMENT
5720 S. UNIVERSITY AVE.
CHICAGO, ILL. 60637

RECEIVED
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**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Johnson Registration District No. 426 File No. _____
 Township _____ Primary Registration District No. 3-3-81 Registered No. 5
 City Chilhowee (No. _____) St. _____ (Ward _____)

2. FULL NAME Lizzie Lavinia 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr. 29 - 1864

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
65 6 3

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Mattoon
 (STATE OR COUNTRY) Ill.

10. NAME OF FATHER W. W. Halbert

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

12. MAIDEN NAME OF MOTHER Mary Logan

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Logan Co. Ky.

14. INFORMANT Mrs Ruth Atkins
 (Address) _____

15. FILED 12/9, 1929 J. S. Bentley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov - 2 - 1929

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(duration) 3 hours yrs. mos. ds.
 CONTRIBUTORY High blood pressure
 (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? Characteristic Symptoms
 (Signed) R. T. Bills, M. D.
 . 19 (Address) Magnolia no

*State the DISEASE CAUSING DEATH, or if 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 Holden Cemetery DATE OF BURIAL Nov 5 1929

20. UNDERTAKER W. W. Goodman ADDRESS Holden Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

RECEIVED DIRECTOR'S OFFICE OF THE FBI

FBI - MEMPHIS

S-37611

COMMUNICATIONS SECTION

APR 4 1968

MEMPHIS, TENNESSEE

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