

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.

WAR 25 1930
411

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

Do not use this space.
4773

1. PLACE OF DEATH
 County Mo. Registration District No. 372 File No. _____
 Township _____ Primary Registration District No. 4218 Registered No. 656
 City Mound City (No. _____) St. _____ Ward _____

2. FULL NAME Esther Darlene 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 S (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 24 1929

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>0</u>	<u>2</u>	<u>20</u>	

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) Mound City
 (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Chas E Baker

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

12. MAIDEN NAME OF MOTHER Sylvia Gabriel

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

14. INFORMANT Chas E Baker
 (Address) Mound City Mo

15. 7-15-30
 FILED _____, 19____ J. O. Franck
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 14 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 14 1930, to Feb 14 1930, (that I last saw h. E.Y. alive on Feb 14 2 a.m., 1930, and that death occurred, on the date stated above, at _____)

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Failure Sarcasm
avalanche
157c (duration) shortly

CONTRIBUTORY (SECONDARY) 159B (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 Physical & x-ray
 (Signed) DeFerry M. D.
Feb 14 1930 (Address) Mound City Mo

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt Hope DATE OF BURIAL 2/15 1930

20. UNDERTAKER W. C. Crawford ADDRESS Mound City Mo

