

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

Do not use this space.

1. PLACE OF DEATH

County North
Township Union
City Grant City Mo. (No.)

Registration District No.
Primary Registration District No. 6215

File No.
Registered No.
St. Ward)

2. FULL NAME

Sarah Jane Baker

(a) Residence. No. St. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mo. da. 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

James S. Baker

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

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, <u>hrs.</u> or <u>min.</u>
<u>68</u>	<u>2</u>	<u>23</u>	

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) housewife

(c) Name of employer Self

9. BIRTHPLACE (CITY OR TOWN)

Grant City, Mo.
(STATE OR COUNTRY) North co.

10. NAME OF FATHER

Geo. W. Miller

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Indiana
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Sarah Cavendish

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Ky.
(STATE OR COUNTRY)

14.

INFORMANT James S. Baker
(Address) Grant City Mo.

15.

FILED....., 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 22 1930

17. I HEREBY CERTIFY, That I attended deceased from January 3, 1930, to March 22, 1930, that I last saw him alive on 3-20, 1930, and that death occurred, on the date stated above, at 4:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mitral regurgitation

92H

11B

(duration) 1 yrs. mo. da.

CONTRIBUTORY (SECONDARY)

Influenza

(duration) 1 yrs. mo. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH. ✓

19. DID AN OPERATION PRECEDE DEATH? NO DATE OF ✓

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS?

Physical findings

(Signed) G. F. Ross, M. D.

, 19 (Address) Grant City 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

Keok Cemetery allendale Mo.

DATE OF BURIAL

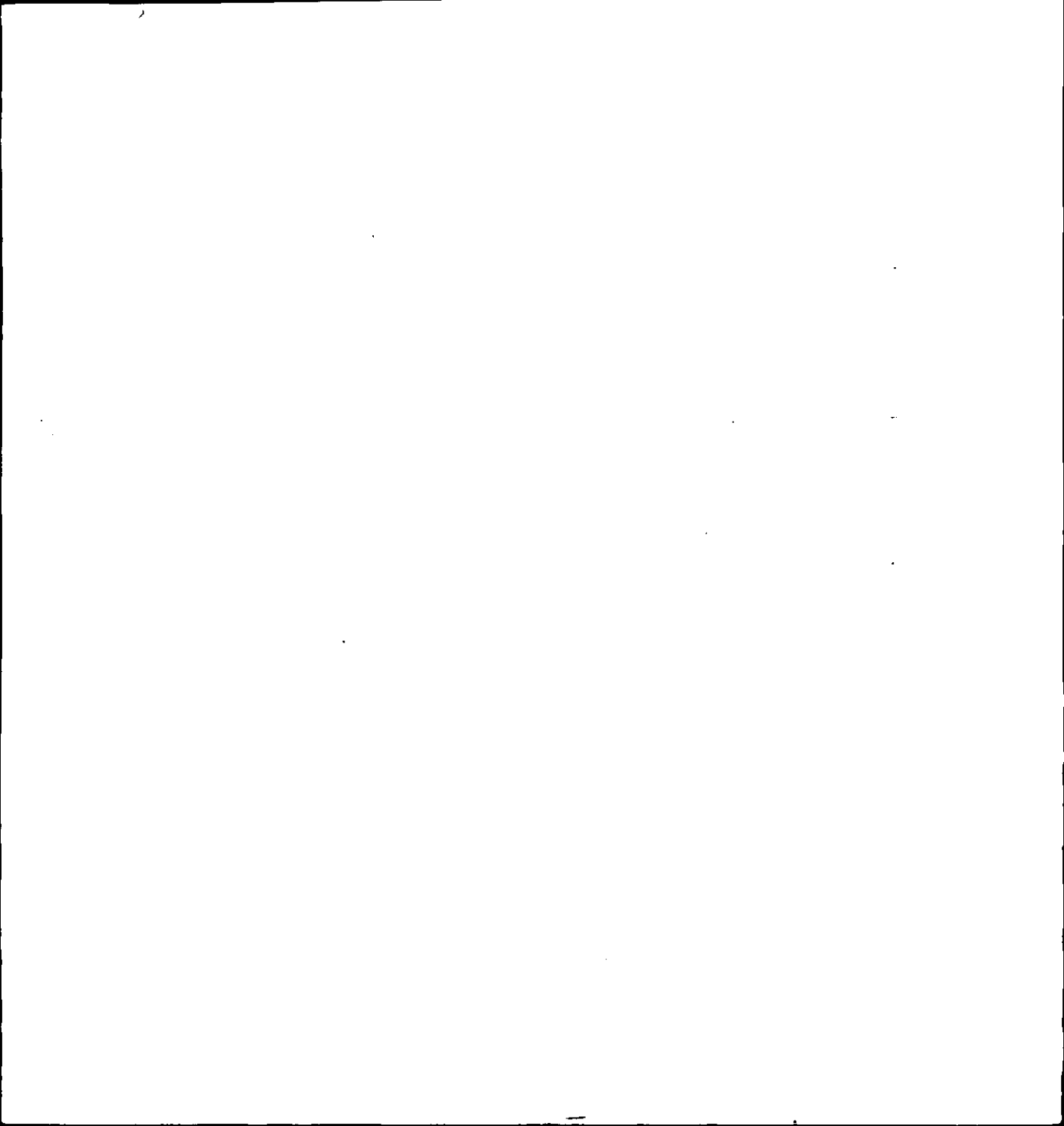
3-26 1930

20. UNDERTAKER

Arch. Duffee

ADDRESS

Grant City Mo.



**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 North
Township Union
City Grant City Mo.

Registration District No. 704
Primary Registration District No. 6215

File No. 6
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 30 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

James L Baker

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

Jan 29-1862

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
68 4 23

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) Housewife
(c) Name of employer self

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

Grant City Mo.
North

10. NAME OF FATHER

Geo. W. Miller

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

Indiana

12. MAIDEN NAME OF MOTHER

Larrah Coville

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

Mo.

14. INFORMANT (Address)

James L Baker
Grant City Mo

15. FILED 7-11 1930 F. J. Johnson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 22 1930

17. I HEREBY CERTIFY That I attended deceased from January 3, 1930 to March 23, 1930 that I last saw h. e. e. on 3-22, 1930, and that death occurred, on the date stated above, at 4:00 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

neural degeneration

CONTRIBUTORY (SECONDARY) Influenza (duration) 1 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? Physiologic findings

(Signed) F. J. Johnson M. D.

, 19 30 (Address) Grant City 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

Trick Cemetery Attendale 3/26 1930

20. UNDERTAKER ADDRESS

Arch Duffee Grant City Mo.

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

S-11522-A