

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.

MAY 28 1930

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

Do not use this space.

15173

1. PLACE OF DEATH

County Wayne
Township York Creek
City 10 (No. 10)

Registration District No. 893
Primary Registration District No. 6189

File No. _____
Registered No. 5-
St. _____ Ward _____

2. FULL NAME

Sarah Alice Baker

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

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. (If nonresident, give city or town and State)

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 Wm. H. Baker

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 10 1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
62 11 23

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. House Keeping
(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) Illinois

10. NAME OF FATHER Lucius Riley
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) North Car.
12. MAIDEN NAME OF MOTHER Magora
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ill

14. INFORMANT Ellis H. Baker
(Address) M. E. Lee Wm.

15. FILED April 1930 Mrs. Hattie McPherson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 3 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 15, 1929, to April 3, 1930.
that I last saw her alive on 4-1, 1930, and that death occurred, on the date stated above, at 9 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer of the stomach
46 E
(duration) 1 yrs. 1 mos. 18 ds.

CONTRIBUTORY (SECONDARY) infection
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED? at her home
IF NOT AT PLACE OF DEATH. ✓

DID AN OPERATION PRECEDE DEATH? No DATE OF ✓

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? none
(Signed) A. T. Kirkpatrick, M. D.

April 1930 (Address) Zaluna 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

Tronaharger Cemetery 4-4 1930
20. UNDERTAKER ADDRESS

James Clark Lowndes, Mo

