

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

Do not use this space.

791

34424

1. PLACE OF DEATH

County.....
Township.....
City..... (No. *City Hospital #2*)

Registration District No.....
Primary Registration District No. **1003**

File No.....
Registered No. **9783**
St..... Ward.....

2. FULL NAME *Charles Baker*

(a) Residence. No. *3130 Franklin St.* *11* 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. da. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *Col* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Single*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *June 29/1882*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>48</i>	<i>3</i>	<i>11</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Comm Labor*
(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) *Hickman Ky*

PARENTS

10. NAME OF FATHER *Prince Baker*

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

12. MAIDEN NAME OF MOTHER *Marial Richardson*

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

14. INFORMANT *Maggie Vinson*

(Address) *3139 Franklin St*

15. FILED *14 1900* *May 6 Starkoff* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *10/10/1930*

17. *No Physician in attendance.*
I HEREBY CERTIFY, That I attended deceased from

..... 19..... to..... 19.....
that I last saw h..... alive on..... 19..... and that death occurred, on the date stated above, at..... *11:30 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Lobar Pneumonia following fractured spine, received when street car struck wagon in which deceased was riding in St. Louis, Mo.
CONTRIBUTORY (SECONDARY) *Criminal Carelessness*
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? *Yes*

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *J. P. Murray*
10/14, 1930 (Address) *Deputy Coroner*

*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

Washington Park Cemetery *10/14/1930*

20. UNDERTAKER ADDRESS *3317*

Miss Lind C Morgan St

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.

101
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101