

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

Do not use this space.

38278

DEC 23 1930

**1. PLACE OF DEATH**

County Sullivan  
Township Union  
City..... (No.....)..... Ward)

Registration District No. 849  
Primary Registration District No. 6115

File No.....  
Registered No. 3-

**2. FULL NAME**

George Henry 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 15 1830

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ..... hrs. or ..... min.
	80	7	1	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer).....  
(c) Name of employer.....

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

10. NAME OF FATHER Geo. Baker

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

12. MAIDEN NAME OF MOTHER Stathan

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

14. INFORMANT Wm P. Baker  
(Address) Steklerville

15. FILED Apr 8, 1930 Miss Kottman  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

17. I HEREBY CERTIFY, That I attended deceased from Nov 4 1930 to Nov 16 1930 that I last saw him alive on Nov 16 1930, and that death occurred, on the date stated above, at 7 P m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Mitral Insufficiency of the heart  
92#

(duration) yrs. mos. ds.

**CONTRIBUTORY (SECONDARY)**

90a

(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?.....

**WHAT TEST CONFIRMED DIAGNOSIS**

(Signed) Russ H. Shaples, M. D.

, 19 (Address) Green 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

Pratt Cem. 11/18 1930

20. UNDERTAKER ADDRESS

Glenn E Kent Green City Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

R. 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.

