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

Do not use this space.

40035

1. PLACE OF DEATH

County: Andrew — Registration District No.: 15

Township: Platte — Primary Registration District No.: 1019

City: Rea — (No. ..... St. ..... Ward)

File No.: 25

Registered No.: 25

2. FULL NAME: James B. Baker

(a) Residence. No. Farm 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.

JAN 10 1932

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*): widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 2-16-1844

7. AGE: Years 87 | Months 9 | Days 28 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Carpenter and farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN): Burksville
(STATE OR COUNTRY): Kentucky

PARENTS

10. NAME OF FATHER: Clay Baker

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

12. MAIDEN NAME OF MOTHER: S. M. Alexander

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

14. INFORMANT: Mrs. Dollie Lease
(Address): Rea, Missouri

15. FILED: DEC 16 1931 C. C. Jeffries
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 12-14 1931

17. I HEREBY CERTIFY, That I attended deceased from Dec 7, 1931, to Dec 14, 1931, that I last saw him alive on Dec 14, 1931, and that death occurred, on the date stated above, at 1 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia
1 DAY
Myocarditis
1 DAY
(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (SECONDARY): Myocarditis
Drugs
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Walter C. Myers, M. D.

, 19 (Address) Savannah 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: Savannah, — DATE OF BURIAL: 12-16 1931

20. UNDERTAKER: J. Fred Terhune — ADDRESS: Savannah Mo.

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

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.