

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

Do not use this space.

18693

1. PLACE OF DEATH

County Shelby
Township Jackson
City _____ (No. _____)

Registration District No. 828
Primary Registration District No. 6040

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

2. FULL NAME

Geo. E 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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 5 - 1858
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
76 8 13

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Shelby Co - Mo.

13. NAME Person Baker

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

15. MAIDEN NAME Dorinda Dodgen

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

17. INFORMANT (ADDRESS) Ray L. Fugger
Shelbyville Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Hill Mo. DATE _____ 19 _____

19. UNDERTAKER (ADDRESS) _____

20. FILED May 22, 1935 Mrs. Lyell Landrum
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 18 1935

22. I HEREBY CERTIFY, That I attended deceased from Nov. 1934, to May 18 1935
I last saw him alive on May 12 1935. Death is said to have occurred on the date stated above, at 4 PM.

The principal cause of death and related causes of importance were as follows:
Septic Larvyngeitis

Other contributory causes of importance:
Engis infection on body
Cause unknown

Name of operation none Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____ 19 _____
Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____

(Signed) D. L. Simpson M. D.
(Address) Bethel Mo

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.

