REC'D APR 11 1939

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

11207
Do not use this space.

49

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.

1. PLACE OF DEATH

(a) County Jasper — Registration District No. 419

(b) Township McDonald — Primary Registration District No. 5573 — Registered No.

(c) City — (d) Street No. — St.
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 360 Jacob Baker

(a) Residence, No. Golden City, Mo. Route #1 St.
(Usual place of abode, if no street address, write county or city) (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): Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Elizabeth W. Baker

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): June 6, 1849

7. AGE: YEARS 89 — MONTHS 9 — DAYS 16 — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Ret. Farmer
9. Industry or business in which work was done, as 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): Terra Haute, Indianna

FATHER
13. NAME: Peter Baker
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Pennsylvania

MOTHER
15. MAIDEN NAME: Elizabeth Austin
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): North Carolina

17. INFORMANT (ADDRESS): W. H. Baker, Golden City, Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Avilla Cemetery DATE 3-24-39, 19

19. FUNERAL DIRECTOR (NAME) (ADDRESS): Ulmer Funeral Home, Carthage, Mo.

20. FILED Mar. 24, 1939 Mrs. W. A. Hall, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): March 22, 1939

22. I HEREBY CERTIFY, That I attended deceased from March 18, 1939, to March 22, 1939
I last saw him alive on March 21, 1939. Death is said to have occurred on the date stated above, at 7:55 p.m.
The principal cause of death and related causes of importance were as follows:

Catarrhal (Lobular) Pneumonia — Date of onset Mch 17-39

1070

Other contributory causes of importance:

Name of operation none — Date of
What test confirmed diagnosis? clinical — Was there an autopsy? no

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) J. M. Brooks, M. D.
379 (Address) Golden City Mo

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ...

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed Ed [illegible]

Licensed Embalmer No. 2222

P. O. Address Carthage

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.