

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.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

28578
Do not use this space.

REC'D SEP 12 1939

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85
 (b) Township _____ Primary Registration District No. 1001 Registered No. 806
 (c) City St. Joseph (d) Street No. State Cancer Hospital # 2 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 260 IKE-BOWMEN-BAKER

(a) Residence, No. _____ St. GOWER - Mo.
 (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) MARRIED

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) AUG. 30, 1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
75 11 7

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. 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) ST. LOUIS COUNTY
 (STATE OR COUNTRY) Mo.

FATHER 13. NAME ABE BAKER

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

MOTHER 15. MAIDEN NAME Susan Brown

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

17. INFORMANT Mrs Elizabeth Baker
 (ADDRESS) Gower, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Crayson Cemetery DATE Aug 3 1939

19. FUNERAL DIRECTOR (NAME) H. A. Sullivan
 (ADDRESS) Gower, Mo.

20. FILED Aug 2 1939 H. J. Nestlebrook
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 2 1939

22. I HEREBY CERTIFY, That I attended deceased from June 21 1939 to August 2 1939
 I last saw him alive on August 2 1939 Death is said to have occurred on the date stated above, at 12:54 p.m.
 The principal cause of death and related causes of importance were as follows:

BRONCHIAL-PNEUMONIA Date of onset 7/21/39

Other contributory causes of importance:
CANCER OF LARYNX 1939

Name of operation TRACHEOTOMY Date of 7-20-39
 What test confirmed diagnosis? Exam 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) Francis Berney, M. D.
 (Address) 311 Northpatrick Blvd 91 St Joseph Mo.

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.....

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

Signed

F. A. Sullivan

Licensed Embalmer No.

1738

P. O. Address.....

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.