

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

33778
Do not use this space.

1. PLACE OF DEATH

(a) County Yexmon Registration District No. 875
 (b) Township Washington Primary Registration District No. 6162 Registered No. 243
 (c) City Arcata or State Hospital #3 (d) Street No. State Hospital #3 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 0 yrs. 0 mos. 5 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 23 Mark Baxter Kingsville, Mo. 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 <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Lawra E. ?</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Nov. 7, 1860</u>		
7. AGE YEARS <u>78</u>	MONTHS <u>10</u>	DAYS <u>12</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Blacksmith</u>		
9. Industry or business in which work was done, as saw mill, bank, etc. <u>-</u>		
10. Date deceased last worked at this occupation (month and year) <u>?</u>		11. Total time (years) spent in this occupation <u>?</u>
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Kentucky</u>		
FATHER	13. NAME <u>Newton H. Baxter</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Kentucky</u>	
MOTHER	15. MAIDEN NAME <u>Sally Hawkins</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Kentucky</u>	
17. INFORMANT (ADDRESS) <u>Records, State Hosp #3</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Kingsville</u> DATE <u>Sept 21, 1939</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>W. Goodman Holder</u>		
20. FILED <u>9-19</u> 19 <u>39</u> <u>Allen & Hayes</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 19, 1939

22. I HEREBY CERTIFY, That I attended deceased from Sept. 14, 1939 to Sept. 15, 1939
 I last saw him alive on Sept. 15, 1939 Death is said to have occurred on the date stated above, at 2:30 p.m.
 The principal cause of death and related causes of importance were as follows:
Lobar Pneumonia
108
 Other contributory causes of importance:
Chronic Myocarditis
Senility

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy? Yes

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) Russ H. Dole M. D.
 (Address) Nevada, 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.

RECEIVED

District Health Officer No. 7,
District File Number 7-39-144
Date Filed 10-11-39

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 Samuel B. Roppo
Licensed Embalmer No. 4044
P. O. Address Holder, Mo.

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

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