

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **33766**
Registrar's No. **8463**

District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri Pacific Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME William Baker

3. (b) If veteran, name war _____ 3. (c) Social Security No. 702-09-0533

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Grace Baker 6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased About 1880
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
About 60 hr. min.

9. Birthplace Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Supervisor

11. Industry or business Railroad

12. Name Unknown

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Grace Baker

(b) Address 1519 S. Waco St Witchita Kansas

17. (a) Removal (b) Date thereof 10/12/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Witchita Kansas

18. (a) Signature of funeral director Robert J. Ambruster

(b) Address 6633 Clayton Road

19. (a) OCT 12 1940 (b) _____
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County _____
(c) City or town St. Witchita 1519 S. Waco St NR
(If outside city or town limits, write "RURAL")
(d) Street No. 1519 South Waco St
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 11
year 1940 hour 11 minute 50 A.M.

21. I hereby certify that I attended the deceased from 9/22/40
_____, 19____, to 10/11/40, 19____;
that I last saw him alive on 10/11/40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Thrombosis
Due to Generalized Arteriosclerosis

Other conditions: Benign Prostatic Hypertrophy
Cerebral Calculus
Major findings: 2 Cerebral Calculi
Of operations _____
Of autopsy: Chest + Abd. neg

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Charles C. Drach (M. D. or other) MD
Address 1755 20 Grand Date signed 10/11/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

(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

Edward H. Beckford

Licensed Embalmer No. *2502*

P. O. Address *Clayton Mo*

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, fact should be so stated above.