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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 34954

NOV 15 1940

Registration District No. 204

Primary Registration District No. 3008

Registrar's No. 275

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

1. PLACE OF DEATH: *Callaway*  
 (a) County *Callaway*  
 (b) City or town *Fulton*  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: \_\_\_\_\_  
 (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) Name of decedent: *Mrs. Mary Elizabeth Baker*  
 FULL NAME  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. *None*

4. Sex: *Female*  
 5. Color or race: *Negro*  
 6. (a) Single, widowed, married, divorced: *Widowed*  
 6. (b) Name of husband or wife: *None*  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased: *Oct 4 1862*  
 (Month) (Day) (Year)

8. AGE: Years *78* Months *—* Days *18*  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace: *Missouri*  
 (City, town, or county) (State or foreign country)

10. Usual occupation: *House Work*

11. Industry or business: \_\_\_\_\_

12. Name: *John Hart*

13. Birthplace: *D.K.*  
 (City, town, or county) (State or foreign country)

14. Maiden name: *D.K.*

15. Birthplace: *D.K.*  
 (City, town, or county) (State or foreign country)

16. (a) Informant: *Mrs. Mary E. Chambers*  
 (b) Address: *Detroit, Mich*

17. (a) *Buried* (b) Date thereof: *Oct 24-40*  
 (Specify whether burial or cremation) (Month) (Day) (Year)  
 (c) Place: burial or cremation: *South Side Cemetery - Fulton Mo*

18. (a) Signature of funeral director: *Chas. Bell*  
 (b) Address: *Fulton Mo*

19. (a) *Oct 24, 1940* (b) *R.N. Crewe*  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State: *Missouri* (b) County: *Callaway*  
 (c) City or town: *Fulton*  
 (If outside city or town limits, write "RURAL")  
 (d) Street No.: *322 N. 9th*  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Oct.* day *30* year *1940* hour *11* minute *—* A. M.  
 21. I hereby certify that I attended the deceased from *Oct 13 th.* 1940 to *Oct. 21st.* 1940;  
 that I last saw *er.* alive on *Oct. 20th.* 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: *Endocarditis, Cardiac hypertrophy, Uremic toxemia, Cystitis marked with hemorrhage.*

Due to: *Rheumatism, vertebrae back.*

Due to: \_\_\_\_\_

Other conditions: *1/2 1/2*  
 (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
 Of operations: \_\_\_\_\_

Of autopsy: *No autopsy*

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) \_\_\_\_\_  
 Means of injury: \_\_\_\_\_

23. Signature: *Chas. Bell*  
 Address: *Fulton Mo* Date signed: \_\_\_\_\_

**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.....

*Eli Bell*

Licensed Embalmer No.....

*2130*

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, fact should be so stated above.**

Registration District No. 104

Primary Registration District No. 3008

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Callaway  
(b) City or town Fulton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mary Elizabeth Baker

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race negro 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year \_\_\_\_\_

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 78 Months \_\_\_\_\_ Days 18 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) May 27, 1941 (b) R. M. Crews  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Oct day 22  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 Greene D McCall \_\_\_\_\_ (Name of physician or other)

Address Fulton Mo \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

