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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **36151**
Registrar's No. **184**

Registration District No. **735** Primary Registration District No. **3034**

1. PLACE OF DEATH:
(a) County **Randolph**
(b) City or town **Moberly**
(c) Name of hospital or institution:
815 Garfield St.
(d) Length of stay: In hospital or institution **none**
In this community **Life**

3. (a) PRINT FULL NAME **ELLA MAE BAKER**
3. (c) Social Security No. **none**
8. (b) If veteran, name war **no.**

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **George Baker** 6. (c) Age of husband or wife if alive **37** years
7. Birth date of deceased **June - 24 - 1906**

8. AGE: Years **34** Months **2** Days **12** If less than one day

9. Birthplace **Jacksonville Missouri**

10. Usual occupation **Housewife**

11. Industry or business
12. Name **Reuben Bowman**
13. Birthplace **Randolph Co Missouri**
14. Maiden name **Annal Pearl Nelson**
15. Birthplace **Randolph Co Missouri**

16. (a) Informant **Annal Pearl Bowman**
(b) Address **1207 Emerson St**

17. (a) **Burial** (b) Date thereof **Sept. 7 - 1940**
(c) Place: burial or cremation **Moberly Missouri**

18. (a) Signature of funeral director **Wm. J. ...**
(b) Address **215 So. 4th St. Moberly Mo.**
19. (a) **Sept 7 - 40** (b) **Leah ...**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Randolph**
(c) City or town **Moberly**
(d) Street No. **815 Garfield St.**
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Sept.** day **5th**
year **1940** hour **5** minute **45**
21. I hereby certify that I attended the deceased from **Aug 30 / 40**
to **Sept 5 / 40**
that I last saw her alive on **Sept - 5 - 1940**
and that death occurred on the date and hour stated above.

Immediate cause of death **Embolic, thrombotic**
Due to **Confusion**

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(e) Means of injury _____
23. Signature **Wm. J. ...** (M. D. or other) _____
Address **Moberly Mo.** Date signed **Sept 7 / 40**

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

144A

RECEIVED

District Health Officer No. 10

District File Number 10-40-1984

Date Filed OCT 24 1940

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 R. M. Carter

Licensed Embalmer No. 4117

P. O. Address Moherly 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 36157

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 735

Primary Registration District No. 3034

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Randolph

(b) City or town mobility
(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 (Specify whether _____)

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) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Ella Mae Baker

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced W

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 Months Days If less than one day

34 2 12 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) _____ (Registrar's signature)

20. DATE OF DEATH Month Sept day 5 year 1940 hour _____ minute _____ M.

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

Immediate cause of death Embolism Thrombosis

Due to _____

14. Confinement
Delivery normal
six days following delivery

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy 1418

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 W. H. Baker (M. D. or other) _____

Address 3192 W. 14th St Date signed _____

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

SUPPLEMENTAL

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

mobility no

