

JAN 25 1941

Registration District No. **735**

Primary Registration District No. **3034**

Registrar's No. **1259**

1. PLACE OF DEATH:

(a) County **Randolph**
(b) City or town **Moberly Mo**
(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 **2 yr** years, months or days **2**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Randolph**
(c) City or town **Moberly Mo**
(If outside city or town limits, write "RURAL")
(d) Street No. **816 Westend Moberly Mo**
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME **WILLIAM M. MARTIN BAKER**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **191-12-6289**

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **1**

6. (b) Name of husband or wife **Mary** 6. (c) Age of husband or wife if alive **43 yr** years

7. Birth date of deceased **May 25 1885**
(Month) (Day) (Year)

8. AGE: Years **55** Months **6** Days **20** If less than one day hr. _____ min. _____

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

10. Usual occupation **Car Salesman** **0**

11. Industry or business **1**

12. Name **J. M. Baker** **0**

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

14. Maiden name **Maggie Kirtley**

15. Birthplace **St. Louis**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Mary Belle Baker**

(b) Address **816 Westend Moberly Mo**

17. (a) **Remove** (b) Date thereof **Dec 17 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Int Olive Cemetery**

18. (a) Signature of funeral director **Tom B. Patton**

(b) Address **Huntsburg Mo**

19. (a) **Dec 17 40** (b) **Leah Williams**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **15** year **1940** hour **8:30 P** minute _____ M.

21. I hereby certify that I attended the deceased from **6:00 AM** **Dec 15**, 1940, to **Death Dec 15**, 1940 that I last saw him alive on **Dec 15**, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Arteriosclerosis** **2 x hrs.**

Due to _____
Due to **44 hr**

Other conditions **none**
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: Of operations **0**
Of autopsy **0**
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? **925** (Specify type of place) While at work? (e) Means of injury _____
23. Signature **Master P. Hunter** (M. D. or other) **M.D.**
Address **Moberly, Mo** Date signed **12/14/40**

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

RECEIVED

District Health Officer No. 10

District File Number 1-41-167

Date Filed JAN 16 1941

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.....

Tom B. Patton

Licensed Embalmer No. 3914

P. O. Address Huntsville, Tenn

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. 735

Primary Registration District No. 3034

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Randolph
(b) City or town Shoberly
(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) PRINT FULL NAME Wm Martin Baker

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

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

6. (b) Name of husband or wife Mary Belle Baker 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 55 Months 6 Days 20 If less than one day _____ 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)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 12/17/40 (b) Leah Williams
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 15
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I 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 Martin Hunter (M. D. or other) _____

Address Shoberly Mo Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

Bell Oxonia 87

July 4-1841

Leanne Munn