

FILED FEB 14 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2670

Registration District No. 327

Primary Registration District No. 4184

Registrar's No. 7

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

1. PLACE OF DEATH:
 (a) County Grundy
 (b) City or town Galt
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community 30yr (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Grundy
 (c) City or town Galt
 (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 ROBERT DEAN BAKER

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

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

6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if alive** dead years

7. Birth date of deceased Dec 13 1894
 (Month) (Day) (Year)

8. AGE: Years 96 Months 1 Days 24 If less than one day hr. _____ min.

9. Birthplace Ind 1
 (City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business _____

12. Name John H Baker

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

14. Maiden name Sarah Husman

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

16. (a) Informant Mrs E R Baker

(b) Address Galt mo

17. (a) (Burial, cremation, or removal) Burial **(b) Date thereof** Feb 9 1941
 (Month) (Day) (Year)

(c) Place: burial or cremation Rural State

18. (a) Signature of funeral director P R Payne & Son
(b) Address Galt mo

19. (a) (Date received local registrar) 2-7-41 **(b) (Registrar's signature)** W. C. Weston

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 6
 year 1941 hour 11 minutes 30 a.m.

21. I hereby certify that I attended the deceased from 1-1-41 to 2-6-41;
 that I last saw him alive on 2-6-41;
 and that death occurred on the date and hour stated above.

Immediate cause of death: Broncho pneumonia Duration 10 da.

Due to Influenza 15 da.

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? 2 a.m.
 While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature W. C. Weston (M. D. or D. O.)
Address Galt, mo **Date signed** 2-7-41

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.....

P. K. Payne Jr.

Licensed Embalmer No.....

3400

P. O. Address.....

Galt

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. 2670

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 327

Primary Registration District No. 4194

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Grundy

(b) City or town Salp
(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) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Robert Dean 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 widowed

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive dead year _____

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

8. AGE:

Years	Months	Days	If less than one day
<u>96</u>	<u>1</u>	<u>24</u>	_____ 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 3-28-41 (b) W. C. Weston
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Feb day 6
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) (r) Means of injury

23. Signature W. C. Weston (M. D. or other) _____
Address Salp Date signed _____

SUPPLEMENTAL COPY

