

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **4729**

Registration District No. **661**

Primary Registration District No. **6171**

Registrar's No. **2**

1. PLACE OF DEATH:

(a) County **WARREN**
 (b) City or town **TRUESDALE**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **1 SALT-11**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **WARREN**
 (c) City or town **TRUESDALE**
 (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 **NORA MARTEN BAKER**

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

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **1 Married**

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

7. Birth date of deceased **Feb 22 - 1874**
 (Month) (Day) (Year)

8. AGE: Years **66** Months **10** Days **18** If less than one day _____ hr. _____ min.

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

10. Usual occupation **At Home**

11. Industry or business _____

12. Name **Thomas Polster**

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

14. Maiden name **Wanney Batts**

15. Birthplace **Gasconade Co, Mo**
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature _____
 (b) Address _____

17. (a) **Burial** (b) Date thereof **Jan 11, 1941**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Warrenton, Mo**

18. (a) Signature of funeral director **J. W. Schilling & Co.**

(b) Address **Warrenton, Mo**

19. (a) **Jan 12, 1941** (b) **[Signature]**
 (Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **10**
 year **1941** hour **11** minute **00 A.M.**

21. I hereby certify that I attended the deceased from **March 1932**
 to **Jan 9**, 19**41**
 that I last saw her alive on **Jan 9**, 19**41**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary sclerosis 2 yr**
 Due to _____

Due to _____
 Other conditions **GHW**
 (include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

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? **802**

While at work? _____ (Specify type of place)
 (a) Means of injury _____

23. Signature **Charles F. Garcia** (M. D. **1/10/41**)
 Address **Warrenton, Mo** Date signed **1/10/41**

PHYSICIAN
 Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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, by

....., Registered Apprentice No.....
working under my personal supervision.

Signed

John F. Nieburg

Licensed Embalmer No... 3897

P. O. Address... Warrenton, 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.