No. 2
4-13-40
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

8321

State File No.

FILED MAR 19 1941

Registration District No. 197

Primary Registration District No. 6040

Registrar's No. 1

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

1. PLACE OF DEATH:
(a) County Saline
(b) ~~City or town~~ Miami
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 20 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Saline 97
(c) City or town R.F.D. Miami, Mo. 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Angie Belle Baker

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex female

5. Color or race white

6. (a) Single, ~~widowed, married~~ ~~divorced~~ single 0

6. (b) Name of husband or wife ✓

6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased Feb. (Month) 4th (Day) 1912 (Year)

8. AGE: Years 28 Months 11 Days 29 If less than one day hr. min.

9. Birthplace Osage Co. (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation at home

11. Industry or business

FATHER
12. Name W. H. Baker
13. Birthplace Osage Co. (City, town, or county) Mo. 0 (State or foreign country)

MOTHER
14. Maiden name Annie Lucindia Horner
15. Birthplace Osage, Co. (City, town, or county) Mo. 0 (State or foreign country)

16. (a) Informant Mr. W. H. Baker
(b) Address Miami, Mo.

17. (a) burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2-5-1941 (Month) (Day) (Year)
(c) Place: burial or ~~cremation~~ Marshall, Mo.

18. (a) Signature of funeral director Hill Brothers
(b) Address Slater, Mo. 974

19. (a) 2-5-41 (Date received local registrar) (b) Mrs Carlina Hisle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 3rd year 1941 hour 2 minute 30 p M.

21. I hereby certify that I attended the deceased from Dec. 2nd, 1940, to Feby 3rd, 1941; that I last saw her alive on Feby 3rd, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis Chronic (Post Influenza)

Due to Acute Influenza

Due to Post Influenza Pneumatitis Acute

Other conditions Anemia Secondary
(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy None

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) None
(b) Date of occurrence
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature H E Lockwood (M. D. or other) MD 0
Address Slater Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 3-4-41

## 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 A. C. Hill

Licensed Embalmer No. 3090

P. O. Address Slater, Mo.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**