

FILED MAR 19 1941

852

Primary Registration District No. **4518**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Sullivan
(b) City or town Milan
(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 64 years years, months or days

3. (a) PRINT FULL NAME

Eliza Rachel Baldrige

8. (b) If veteran, _____ name war

3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Chester A. Baldrige 6. (c) Age of husband or wife if alive dead years
7. Birth date of deceased: May 9 1876 (Month) (Day) (Year)

8. AGE: Years 64 Months 9 Days 7 If less than one day _____ hr. _____ min.

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

10. Usual occupation At Home

11. Industry or business

MOTHER FATHER { 12. Name David Mc Kinsey
13. Birthplace Indiana (City, town, of county) (State or foreign country)
14. Maiden name Lucinda J. Wipe
15. Birthplace Indiana (City, town, of county) (State or foreign country)

16. (a) Informant Mr. Sam Mc Kinsey

(b) Address Pollock, Mo.

17. (a) Burial (b) Date thereof Feb 18 1941 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elywood Cem

18. (a) Signature of funeral director Schoenes

(b) Address Milan, Mo.

19. (a) Mar 8 1941 (b) Cleo Aggar (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Sullivan
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Febr. day 16 year 1941 hour 10 minute 20.2 A.M.

21. I hereby certify that I attended the deceased from Jan 4th 1941, to Feb 16th 1941; that I last saw her alive on Feb 16th 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy or Cerebral Hemorrhage with hemiplegia and ataxia
Due to Hypertension or Arteriosclerosis
Due to _____
Other conditions (Include pregnancy within 3 months of death) 72 hr
Major findings: _____
Of operations _____
Of autopsy _____

Duration

8 yrs.

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 Grace Simmons (M.D. or other) DO

Address Milan Mo. Date signed 2/20/41

MAR 9 1950

RECEIVED

District Health Officer No. 10

District File Number 3-41-585

Date Filed MAR 10 1949

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

Frank D. Schoene

Registered Apprentice No.

working under my personal supervision.

Signed

Frank D. Schoene

Licensed Embalmer No.

2016

P. O. Address

Milan, 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.