

1. PLACE OF DEATH:

(a) County Stone
(b) City or town Rural Grant Twship
(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 George R Baker

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

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Minnie Baker 6. (c) Age of husband or wife if alive 53 years
7. Birth date of deceased Sept, 11 1884
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
56 8 24 hr. min.

9. Birthplace Stone County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business.

12. Name Abb Baker
13. Birthplace ? Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Nancy Dennis
15. Birthplace ? Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Minnie E Baker
(b) Address Marionville Mo R 1
17. (a) Burial (b) Date thereof 6/5/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crane Mo.

18. (a) Signature of funeral director G. F. King

(b) Address Aurora Mo.

19. (a) 6-7-1941 (b) N. G. Schuman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stone
(c) City or town Rural (Grant Twship)
(If outside city or town limits, write "RURAL")
(d) Street No. R.F.D. # 1 Marionville Mo.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 4
year 1941 hour 3 minute 00 A. M.

21. I hereby certify that I attended the deceased from June 3
19 41 to June 3 19 41
that I last saw him alive on June 3 19 41
and that death occurred on the date and hour stated above.

Immediate cause of death Septicemic, acute
gangrenous, necrotic
Due to Parasitosis
gastrointestinal (gawler)
Due to Extraction of
Molar Teeth

Other conditions (Include pregnancy within 3 months of death)

Major findings: Extraction of
Left Upper Molar
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?

(Specify type of place) (e) Means of injury
While at work?
23. Signature Dr. Kenneth S. Kline (M. D. or other)
Address 16 E. Chestnut St Date signed 6/4/41

Kelsoy

Mr. H. A. Danner
Hurley Mo.

RECEIVED
District Health Officer No. 6,
District File Number 641-929
Date Filed JUN 10 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.....

Herman L. Luridge

Licensed Embalmer No. 3072

P. O. Address Cairo 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, fact should be so stated above.