

2
4-41
-39
X26390

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 25182

Reg. District No. 334

Primary Registration District No. 4197

Registrar's No. 47

1. PLACE OF DEATH:

(a) County Harrison

(b) City or town Bethany Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Bethany Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 days
(Specify whether years, months or days) 35 or 40 years

3. (a) PRINT FULL NAME Maggie M Baker

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced divorced

6. (b) Name of husband E O Baker Deced 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan 13 1870
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>71</u>	<u>6</u>	<u>11</u>	hr. min.

9. Birthplace Near Berea Kentucky
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business _____

MOTHER FATHER {

12. Name Frank Holloway

13. Birthplace Madison Co Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Armina Perry

15. Birthplace Madison Co Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Curtis B. Baker

(b) Address Blytheville Mo

17. (a) Burial (b) Date thereof July 27 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Miriam Cemetery

18. (a) Signature of funeral director Joe E. Wheeler

(b) Address Bethany Mo

19. (a) 7/30/41 (b) Zola M. Burris
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Harrison

(c) City or town Blytheville Mo. 40
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24
year 1941 hour 10 minute 30 P.M.

21. I hereby certify that I attended the deceased from May 31 1941 to July 24 1941
that I last saw her alive on July 24 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis -

Duration 5 years

Due to 93d

Due to _____

Other conditions acute nephritis
(Include pregnancy within 3 months of death) 2 weeks

Major findings: Of operations none

Of autopsy no

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 J. E. Wheeler (M. D. or other) no

Address Bethany Missouri Date signed 7/26/41

(Licensed Embalmer's Statement on Reverse Side)

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

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..... *Joe E. Wheeler*

Licensed Embalmer No..... *3512*

P. O. Address..... *Anthony Mo*

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

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 25-182
Registrar's No. 47

Registration District No. 334

Primary Registration District No. 4197

1. PLACE OF DEATH:
(a) County Harrison
(b) City or town Bethany
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Bethany Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 dd
In this community (25 or 40 years)
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Harrison
(c) City or town Blythedale
(If outside city or town limits, write "RURAL")
(d) Street 1st
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Maggie M. Baker
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

20. DATE OF DEATH: Month July Day 24 Year 1941 Hour _____ Minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him/her alive on _____ 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

4. Sex F 5. Color or race W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

Duration _____
Due to _____
Due to _____
Other conditions _____ (include pregnancy within 3 months of death)
Major findings: _____
Of operations _____
Of autopsy _____

8. AGE: Years 71 Months _____ Days _____ If less than one day _____ min.
9. Birthplace _____ (City, town, or county) _____ (State or foreign country)
10. Usual occupation _____
11. Industry or business _____
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)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant _____ (b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) _____
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____ (b) Address _____
19. (a) 9/18/41 (b) Zola M. Burns
(Date received local registrar) (Registrar's signature)

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)
(b) 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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

Zola M. Burns

S-25182