

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **25396**

AUG 14 1941

Union District No. **448**

Primary Registration District No. **6608**

Registrar's No.

1. PLACE OF DEATH:

- (a) County **Indian**
(b) City or town **Conway**
(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 **1** (Specify whether years, months or days)
In this community **1** years, months or days

3. (a) PRINT FULL NAME **EVA 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 **Widowed**
6. (b) Name of husband or wife **Wesley Baker** 6. (c) Age of husband or wife if alive **36** years
7. Birth date of deceased **May - 26 - 1889** (Month) (Day) (Year)

8. AGE: Years **82** Months **2** Days **8** If less than one day hr. min.

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

10. Usual occupation **Housekeeper**

11. Industry or business

12. Name **Albion Personnel**
13. Birthplace **Indiana** (City, town, or county) (State or foreign country)
14. Maiden name **Frances Ward**
15. Birthplace **Ohio** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs J. E. Walker**
(b) Address **Pueblo Mo**

17. (a) (Burial, cremation, or removal) (b) Date thereof **8-6-41** (Month) (Day) (Year)
(c) Place: burial or cremation **Marion Cemetery**

18. (a) Signature of funeral director **E. J. Jones**
(b) Address **1240 E. 1st St. Pueblo Mo**

19. (a) **8-8-41** (Date received local registrar) (b) **Grace Price** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Missouri** (b) County **Laclede**
(c) City or town **Conway** (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **4** year **1941** hour **5** minute **30** M.

21. I hereby certify that I attended the deceased from **7-30**, 1941, to **8-4**, 1941
that I last saw her alive on **8-4**, 1941
and that death occurred on the date and hour stated above.

- Immediate cause of death **Cerebral Hemorrhage**
Due to **Arterial Sclerosis**

- Due to **97**
Other conditions (include pregnancy within 3 months of death)

- Major findings: Of operations
Of autopsy
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. W. Lindsey** (M. D. or other) **MD**
Address **Conway** Date signed **8-7-41**

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

RECEIVED
District Health Officer No. 7,
District File Number 2141/1299
Date Filed 2/12/44

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

Leonard B. Jones

Licensed Embalmer No. 2508

P. O. Address Buffalo, N.Y.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 25396

Registration District No. 448

Primary Registration District No. 5208

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Laclede
(b) City or town Conway
(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 Eva 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 wid
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)

8. AGE: Years _____ 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)

16. (a) Informant _____

(b) Address _____

17. (a) Aug 6-41 (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation Marlin

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 8-8 (b) Grace Price
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Laclede
(c) City or town Conway
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 6 year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 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 _____ Duration _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

S-25396