

FILED JAN 11 1942

Registration District No. \_\_\_\_\_

Primary Registration District No. 2000

Registrar's No. 864

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

1. PLACE OF DEATH:

(a) County GREENE  
 (b) City or town SPRINGFIELD  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 1033 N. FLORENCE  
 (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 YR. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene  
 (c) City or town Springfield  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 1033 N. Florence (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME LOUISA BAKER

3. (b) If veteran, name war NONE 3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 3rd  
 year 1942 hour 1 minute 10 P. M.

4. Sex FEMALE 5. Color or race WHITE  
 6. (a) Single, widowed, married, divorced, WIDOW  
 6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive Dec 21 1858  
 7. Birth date of deceased OCT. 21 1858  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 11-27-1942 to 12-1-1942  
 that I last saw her alive on 12/2/1942  
 and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Pericarditis  
 Due to Epithelioma with metastasis  
 Due to \_\_\_\_\_

8. AGE: Years 84 Months 1 Days 12 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Unknown ILL. (City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business IN HOME

12. Name GAMPSON HARRIS

13. Birthplace Unknown UNKNOWN? (City, town, or county) (State or foreign country)

14. Maiden name JANE SUMMERS (State or foreign country)

15. Birthplace Unknown UNKNOWN? (City, town, or county) (State or foreign country)

16. (a) Informant George E. Baker

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof Dec 5, 1942  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Seaton Cem. Dixon Mo.

18. (a) Signature of funeral director J. W. Hingert

(b) Address Springfield, Mo.

19. (a) 12-5-42 (b) J. W. Hingert  
 (Date received local registrar) (Registrar's signature)

Other conditions Senility  
 (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 C. E. Feller (M. D. certifier)  
 Address Springfield, Mo. Date signed 12-2-42

987

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**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

*Roy A. Leavin*

Licensed Embalmer No.

*1763*

P. O. Address

*Springfield 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.**

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MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 40721  
Registrar's No. 864

Registration District No. 128 Primary Registration District No. 2000

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Springfield  
(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 20 yrs  
years, months or days)

3. (a) PRINT FULL NAME Louisa 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 Oct 21  
(Month) (Day) (Year)

8. AGE: Years 84 Months 1 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 Dampson Harris

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name Jane Summers

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Greene  
(c) City or town Springfield  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1033 W Florence  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 31  
year 1942 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 Epithelioma neck

Due to Fracture bone on left temporal region

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

