

DEPARTMENT OF COMMERCE

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 127

1. PLACE OF DEATH

(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution Copley Nursing Home
(d) Length of stay: In hospital or institution _____
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County St. Louis
(c) City or town North St. Louis
(d) Street No. Copley Nursing Home
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Jacob C. Baker

3. (b) If veteran name war _____

3. (c) Social Security No. W

4. Sex Male 5. Color or race W

6. (a) Single, widowed, married, divorced 2

6. (b) Name of husband or wife Unknown

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb 26 1863

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>10</u>	<u>20</u>	hr. _____ min. _____

9. Birthplace Norfolk Va

10. Usual occupation Retired

11. Industry or business unk

MOTHER FATHER

12. Name unk

13. Birthplace Unknown Va

14. Maiden name unk

15. Birthplace Unknown Va

16. (a) Informant W. V. Baker

(b) Address 2538 Brenton Rd

17. (a) Removal (b) Date thereof 1-16-44

(c) Place: burial or cremation Chicago Ill

18. (a) Signature of funeral director Lochie H. Bopp Inc

(b) Address Kirkwood Mo

19. (a) JAN 18 1944 (b) E. J. Mc Larran, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 15
year 1944 hour 10 minute P M.
21. I hereby certify that I attended the deceased from November 21, 1943 to Jan 15, 1944
that I last saw him alive on Jan 10, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Cardiac Dilatation Duration 1 day
Due to Chronic myocarditis 5 yrs
Due to arteriosclerosis 10 yrs
Other conditions Arthritis deformans 5 yrs
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy 93d

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 W. H. Sheslie (M. D. or other) unk
Address Kirkwood, Mo Date signed 1/16/44

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

JAN 26 1977

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 Felix Durand

Licensed Embalmer No. 3034

P. O. Address Kutwood ms

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.