

FILED APR 13 1944

State File No.

Registration District No. 19

Primary Registration District No. 3014

Registrar's No. 34

1. PLACE OF DEATH:

(a) County Clay
 (b) City or town Liberly
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Colonial Hotel 3
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay 24
 (c) City or town Liberly 3
(If outside city or town limits, write "RURAL") 1
 (d) Street No. 112 E Franklin
(If rural, give location)
 (e) Citizen of foreign country?.....
(Yes or No)
 If yes, name country..... 0

3. (a) PRINT FULL NAME John Earl Baker

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced 2

6. (b) Name of husband or wife Mrs Mary Baker 6. (c) Age of husband or wife if alive dec years

7. Birth date of deceased August 13 1876
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>7</u>	<u>10</u>	hr. min.

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

10. Usual occupation Hotel manager

11. Industry or business Hotel

12. Name William Baker

13. Birthplace Ohio 1
(City, town, or county) (State or foreign country)

14. Maiden name Mary Baker

15. Birthplace Ohio 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. E.M. Howe

(b) Address 6017 N. Lee Kansas City, Mo

17. (a) Removal (b) Date thereof March 23, 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City, Mo

18. (a) Signature of funeral director Stine & McClure

(b) Address Kansas City, Mo

19. (a) March 23 1944 (b) Aelen Early
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 23
 X year 1944 hour 1 minute 15 A.M.

21. I hereby certify that I attended the deceased from Mar 22 1944 to Mar 23 1944
 that I last saw him alive on Mar 23 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Angina Pectoris

Due to.....
 Due to.....

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

Major findings:
 Of operations.....

Of autopsy.....

Duration

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) (c) Means of injury.....

23. Signature Burton Malthe (M. D. or other) M.D.
 Address Liberly Mo Date signed 3-3-44

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8

District File Number

Date Filed

4-12-44

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

John L. Shurley

Licensed Embalmer No. 4058

P. O. Address. Kansas City 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.

2B
43
K36930

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. April
Registrar's No. 34

Registration District No. 73

Primary Registration District No. 3014

1. PLACE OF DEATH:

(a) County Clay
(b) City or town Liberty
(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: Approximately 2 years
years, months or days

3. (a) PRINT FULL NAME

John Earl Baker

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased: Aug. 13 (Month) (Day) (Year)

8. AGE: Years 73 Months 7 Days 7 (unless 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) _____ (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) _____ (b) Helen Early (Registrar's signature)
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 March day _____ year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ 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)
(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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

102098