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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14811 ✓

State File No. \_\_\_\_\_

FILED MAY 2 1944  
Registration District No. 147

Primary Registration District No. 5569

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County JACKSON

(b) City or town RURAL - BRANKING TWP  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
63RD WOODSON ROAD - R.R. #5 - INDEPENDENCE  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 30 YEARS (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON

(c) City or town INDEPENDENCE 48  
(If outside city or town limits, write "RURAL")

(d) Street No. R.R. #5 - 63RD WOODSON ROAD  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MRS. ALICE HARDEN BAKER

3. (b) If veteran, name war No

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 21 ST  
year 1944 hour 10 minute 00 A.M.

21. I hereby certify that I attended the deceased from February 2 1944  
1944 to March 21 1944  
that I last saw her alive on March 20 1944  
and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race WHITE

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

6. (b) Name of husband or wife MR. GEORGE BAKER

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

7. Birth date of deceased NOVEMBER 15 1865  
(Month) (Day) (Year)

Immediate cause of death Carcinoma of Cervix Uteri

Duration 2 yrs

8. AGE: Years Months Days If less than one day

78 4 6 hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

10. Usual occupation AT HOME

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name UNKNOWN HARDEN

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

14. Maiden name SOPHIA ROCH

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

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Winnie Baker

(b) Address Indep. R.R. #5

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR 23 1944  
(Month) (Day) (Year)

(c) Place: burial or cremation FLORAL HILLS CEM.

18. (a) Signature of funeral director D. H. Newcomer, Inc.

(b) Address KANSAS CITY, MISSOURI

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(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)

(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 John E. Lapp (M. D. or other) MD

Address 304 Professional Bldg Date signed Mar 22 1944

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

149

(Licensed Embalmer's Statement on Reverse Side)

13140  
C-1

**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 *H. O. Newcome Jr*  
Licensed Embalmer No. 4043  
P. O. Address *H. O. Newcome*

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. May  
Registrar's No. \_\_\_\_\_

Registration District No. 147 Primary Registration District No. 5569

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

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Rural Brookings  
(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 \_\_\_\_\_ (Specify whether  
years, months or days)

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 \_\_\_\_\_

3. (a) PRINT FULL NAME Alice Haden Baker  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month March day 21  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex F 5. Color of race W 6. (a) Single, widowed, married, divorced W  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Nov 15 1886  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death Carcinoma of Cervix uteri Duration \_\_\_\_\_

8. AGE: Years 78 Months 4 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.  
9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

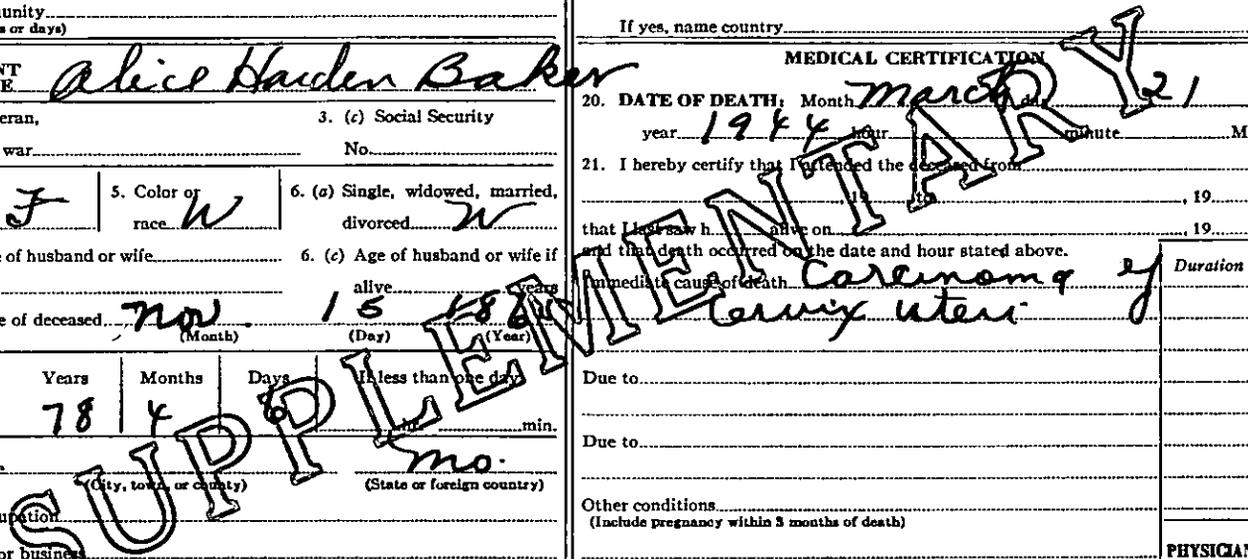
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_  
17. (a) (Burial, cremation, or removal) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_  
19. (a) 3-23-44 (b) [Signature]  
(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)  
(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 \_\_\_\_\_



14811