

FILED JUN 9 1944

Registration District No. 179Primary Registration District No. 6380Registrar's No. 203

1. PLACE OF DEATH:

(a) County DeKalb
(b) City or town Stewartsville, Rural, Wash
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1 Jump
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community 50 yrs.
years, months or days)

3. (a) PRINT
FULL NAMERobert, C. Baker.

3. (b) If veteran,

name war _____

3. (c) Social Security

No. _____

4. Sex Male 5. Color or White
6. (a) Single, widowed, married, Married
divorced _____
(b) Name of husband or wife _____
(c) Age of husband or wife if
alive 76 years
7. Birth date of deceased Sept 12 1864
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
79 8 0 _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name Milton D. Baker.

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

14. Maiden name Elenora Vance

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

16. (a) Informant Walker Baker

(b) Address Stewartsville Mo.

17. (a) _____ (b) Date thereof May 15, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Stewartsville Mo.

(b) Address Stewartsville Mo.

19. (a) May 14 1944 (b) John Clouse
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County 32
(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 May day 12
year 1944 hour 6 minute 20 M.

21. I hereby certify that I attended the deceased from July
12, 1944, to May 12, 1944
that I last saw him alive on May 12, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death

apoplexy

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 sta-
tistically.

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 M. S. Gale (M. D. or other) _____
Address Stewartsville Mo. Date signed 5/14/44

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.....

F. G. Jones

Licensed Embalmer No. 952

P. O. Address. Stewartsville Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply - 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.

Registration District No. 99Primary Registration District No. 5380Registrar's No. 203

1. PLACE OF DEATH:

- (a) County De Kalb
(b) City or town Rural Washburg
(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 NAMERobert C. 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 m

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

7. Birth date of deceased
- Sept 12 1864
-
- (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
79 8 12 min.

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

10. Usual occupation
- Farmer

11. Industry or business

12. Name
- Milton D. Baker
-
13. Birthplace
- Mo.
-
- (City, town, or county) (State or foreign country)

14. Maiden name
- Elnora Vance

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

16. (a) Informant
- Walter Baker

- (b) Address
- Steubenville Mo

17. (a) (b) Date thereof
- 5-15-44
-
- (Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or
- Memorial Park Cem.

18. (a) Signature of funeral director
- R. S. Lyon

- (b) Address
- Steubenville Mo

19. (a)
- 5-14-44
- (b)
- John Clarke
-
- (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County De Kalb
(c) City or town Steubenville (Rural)
(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 May 12
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.....

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