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V. S. No. 2  
50M-5-42  
Rev. 5-17-39  
I, X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED JUL 7 1944

Registration District No. 369

Primary Registration District No. 6228

Registrar's No. ....

W. Allen  
108

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

1. PLACE OF DEATH:

(a) County Harrison

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

(c) Name of hospital or institution General  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 1/2 years  
(Specify whether years, months or days)

In this community 6 1/2 years  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Della May Baker

3. (b) If veteran.  name war ✓

3. (c) Social Security No. ✓

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife P. A. Baker

6. (c) Age of husband or wife if alive 65 yrs years

7. Birth date of deceased July 26 1878  
(Month) (Day) (Year)

8. AGE: Years 65 Months 6 Days 28 If less than one day hr. min.

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

10. Usual occupation Operator Telephone Exchange

11. Industry or business Operator Telephone Exchange

12. Name Robert Wagner

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

14. Maiden name Agnes M. Lister

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

16. (a) Informant Mrs. J. C. Knox

(b) Address Statesbury Mo

17. (a) Burial, cremation, or removal Buried

(b) Date thereof Feb 27-44  
(Month) (Day) (Year)

(c) Place: burial or cremation Kampman Cemetery

18. (a) Signature of funeral director W. C. Cheney

(b) Address 414 Scott Kansas

19. (a) 6-15-44 (Date received local registrar)

(b) Mrs. W. L. Charles (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Harrison

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

(d) Street No. General  
(If rural, give location)

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

If yes, name country ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 24 year 1944 hour 3 minute 30 AM

21. I hereby certify that I attended the deceased from July 1943 to Feb 24 1944 that I last saw h. alive on Feb 24 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Insufficiency 1 yr

Due to Arteriosclerosis 3 yrs

Due to 92 f

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 92 f

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) (c) Signs of injury

23. Signature W. Allen (M. D. or other)

Address Statesbury, Mo. Date signed 2/26/44

1250

License No. 769  
Date Filed 7-6-44

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, OK

-----, Registered Apprentice No. -----  
working under my personal supervision.

Signed O. A. Cheney

Licensed Embalmer No. 2613

P. O. Address Fort Scott, Kansas

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.