V. S. No. 2
00M—5-43
Rev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 24098

FILED JUL 27 1944

Registration District No. 1000

Primary Registration District No. 1000

Registrar's No. 745

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution: 1422 North 3 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether

In this community 26 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Buchanan

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

(d) Street No. 1422 North 3 (If rural, give location)

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

If yes, name country 0

3. (a) PRINT FULL NAME MICHAEL - BAKER

3. (b) If veteran, name war no

3. (c) Social Security No.

4. Sex M

5. Color or race Wht

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

6. (b) Name of husband or wife Clarice Virginia

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

7. Birth date of deceased March 17 1895 (Month) (Day) (Year)

8. AGE: Years 49 Months 3 Days 24 If less than one day hr. min.

9. Birthplace Mt Vernon Ark. (City, town, or county) (State or foreign country)

10. Usual occupation Ret. Employee

11. Industry or business Western Dairy Co

FATHER
12. Name unk
13. Birthplace unk (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name unk
15. Birthplace unk (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Michael Baker

(b) Address St Joseph Mo.

17. (a) - B - (Burial, cremation, or removal) (b) Date thereof 7-13-44 (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cem

18. (a) Signature of funeral director Stainer Funeral Home

(b) Address St Joseph Mo

19. (a) 7/13/44 (Date received local registrar) (b) Helen I. Pickle (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month July day 11 year 1944 hour 11.30 minute a M.

21. I hereby certify that I ~~attended~~ viewed the deceased ~~from~~ on July 11th, 1944, to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Pulmonary Tuberculosis — Duration 2 yrs

Due to 13 b 1

Due to

Other conditions (Include pregnancy within 3 months of death) Man has been suffering with pulmonary tuberculosis for the past two years, taking no treatments at Mt Vernon, Mo and the St Joseph T.B. clinics.

Major findings of operations

Of autopsy

PHYSICIAN — Underline the cause to which death should be charged critically.

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature H F Mundy (M. D. ~~or other~~) Coroner

Address 404 So 3rd St Date signed 7/11/44

1377

(Licensed Embalmer's Statement on Reverse Side)

OCT 19 1945

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 Roy Clowney

Licensed Embalmer No. 2435

P. O. Address St Joseph 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.