

FILED AUG 12 1944
Registration District No. 296

Primary Registration District No. 5947

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Phelps
(b) City or town St James Farmhouse
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Soldiers Home Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 1/2 hours
(Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Phelps
(c) City or town _____
(If outside city or town limits, write "RURAL") 0
(d) Street No. _____
(If rural, give location) 0
(e) If foreign born, how long in U. S. A.? 0 years.

In this community _____ years, months or days)
3. (a) PRINT FULL NAME Della Baker

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 6
year 1944 hour 87 minute 10 P. M.

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

21. I hereby certify that I attended the deceased from Jan 24 - 1944, to July 6 1944, 1944.
that I last saw her alive on July 6 1944, 1944.
and that death occurred on the date and hour stated above.

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

Immediate cause of death Chronic int. Nephritis Duration 3 y

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 28 1866
(Month) (Day) (Year)

Due to _____
Due to _____

8. AGE: Years 82 Months 11 Days 22 If less than one day _____ hr. _____ min.

Other conditions (include pregnancy within 3 months of death) gla

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

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

10. Usual occupation House wife

11. Industry or business _____

12. Name Don't know

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's own signature Soldiers Home Office
(b) Address St James Mo

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? _____

17. (a) Removal (b) Date thereof 7-8-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation East Pagurus Mo

While at work? _____ (Specify type of place) (a) Means of injury _____

18. (a) Signature of funeral director W C Lockholder
(b) Address St James Mo
19. (a) 7-7-1944 (b) Phaulle Jackson
(Date received local registrar) (Registrar's signature)

23. Signature William Storer (M. D. or other) _____
Address St James, Mo Date signed 7/6/44

MOTHER FATHER

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.....

..... *me*, Registered Apprentice No.....
working under my personal supervision.

Signed *Orville E. Lee Rhoades*

Licensed Embalmer No. *3546*

P. O. Address *17 James*

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, above space should be left blank.

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Registrar's No. _____

1. PLACE OF DEATH:

(a) County Phelps
(b) City or town St James Miss
(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 NAME Della Baker

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

4. Sex F 5. Color or 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 _____ year

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 87 Months 10 Days _____ If less 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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Phelps
(c) City or town St James (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 July 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

MOTHER FATHER

25442