

FILED JAN 25 1945
149

Registration District No. _____

Primary Registration District No. **1002**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Healthy Prominent Hospital 1876 7th**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 days**
(Specify whether _____)
In this community **over 20 yrs**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **1610 E. 22nd Terrace**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **William E. Baker**

3. (b) If veteran, **Yes** name war **World War I**
3. (c) Social Security No. **495-10-7616**

4. Sex **Male** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Lillian Baker** 6. (c) Age of husband or wife if alive **31** years

7. Birth date of deceased **Oct-10-1888**
(Month) (Day) (Year)

8. AGE: **56** Years **2** Months **27** Days **24**
If less than one day hr. min.

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

10. Usual occupation **Janitor**

11. Industry or business **Donnley Co**

12. Name **William Chas. Baker**

13. Birthplace **Alton Ill**
(City, town, or county) (State or foreign country)

14. Maiden name **Lydia Moeze**

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

16. (a) Informant **Lillian Baker**

(b) Address **1610 E. 22 Terr**

17. (a) **Burial** (b) Date thereof **1-8-1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Highland Cem.**

18. (a) Signature of funeral director **West Appleton Jones**

(b) Address **1905 Vine St**

19. (a) **1-8-45** (b) **N. E. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **4** year **1945** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **Jan 2** to **Jan 4**, 19**45**
that I last saw him alive on **Jan 4**, 19**45**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebro Spinal meningitis**
Due to **meningo cocci** Duration **2**

Due to **6.**
Other conditions **Toxemia**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy **none**
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)
Means of injury _____

23. Signature **W. Hillman** (M.D. or other) **MD**
Address **1618 83rd** Date signed **1/7/45**

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

MOTHER FATHER

FEB 16 1945

FEB 8 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.....

Licensed Embalmer No. *2710*

P. O. Address *Kansas City*

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.