

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 25 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3768

State File No.

Registration District No. 346

Primary Registration District No. 6164

Registrar's No. 30

1. PLACE OF DEATH:

(a) County Stone
(b) City or town Rural Grant Twnship
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
R.F.D. # 1 Marionville Mo
(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 Minnie 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, Widowed
6. (b) Name of husband or wife George Baker 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug. 7 1887
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
56 0 28 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Joe Quick
13. Birthplace ? Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Jane Newman
15. Birthplace ? Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Ruby Baker
(b) Address R # 1 Marionville Mo
17. (a) Burial (b) Date thereof 9/7/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crane Mo
18. (a) Signature of funeral director J. F. King
(b) Address Aurora Mo
19. (a) 9/13/43 (b) George Neubre
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stone cc 104
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. R.F.D. # 1 Marionville Mo.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 5
year 1943 hour 6 minute 45 P.M.

21. I hereby certify that I attended the deceased from August 13 to September 5, 1943
that I last saw her alive on September 5, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Memia
Malignant Hypertension
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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? _____

(Specify type of place)
While at work? _____ (c) Means of injury _____
23. Signature A. P. Cooper (M. D. or other) MD
Address Home Mo Date signed 9-6-43

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

1174

RECEIVED
District Health Officer No. 6,
District File Number 145-90
Date Filed JAN 17 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..... *Herman M. Surri*

Licensed Embalmer No. 3072

P. O. Address..... *Aurora, Ill.*

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Feb
Registrar's No. 30

Registration District No. 346 Primary Registration District No. 6164

1. PLACE OF DEATH:

(a) County Stone
(b) City or town Rural Shand Twp
(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

Minnie 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 _____ years

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

8. AGE: Years 56 Months 0 Days 2 (Unless than one day) min. 0

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 _____ (b) County _____
(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 Sept year 1940 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 _____

Due to Infarction of myocardium
Due to Hypertension

Other conditions _____ (Include pregnancy within 3 months of death)

ADDITIONAL INFORMATION REQUESTED
Major findings: Of operations finally ended up with pneumonia
Of autopsy _____

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 B. P. Chidmore (M. D. or other) _____
Address Crane, Mo Date signed Feb 50

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

SUPPLEMENTARY

PHYSICIAN

Underline the cause to which death should be charged statistically.

3768