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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED FEB 16 1945

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 3952  
Registrar's No. 1061

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:  
(a) County.....  
(b) City or town..... St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Louis City Hospital - Max C. Starkloff Memorial  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 1 mo - 6 days  
(Specify whether  
In this community.....  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State. Missouri (b) County.....  
(c) City or town..... St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1706 No. 11th St.,  
(If rural, give location)  
(e) Citizen of foreign country? yes (Yes or No)  
If yes, name country..... 0

3. (a) PRINT FULL NAME Harold Baker  
3. (b) If veteran, name war. nil 3. (c) Social Security No. none  
4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased. March 8th, 1944  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Feb. day 2nd  
year. 1945 hour. 8:35 minute. A. M.  
21. I hereby certify that I attended the deceased from 12/26/44  
....., 19....., to 2/2/45....., 19.....;  
that I last saw h. im alive on 2/2/45....., 19.....;  
and that death occurred on the date and hour stated above.

Immediate cause of death.....  
Chronic Diarrhea and Colic 1 mo  
Due to Chronic Otitis Media 1 mo  
Due to.....  
Other conditions.....  
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day  
10 24 hr. min.  
9. Birthplace. St. Louis, Missouri (City, town, or county) (State or foreign country)  
10. Usual occupation infant  
11. Industry or business.....  
12. Name. Naymon Baker  
13. Birthplace. Unknown - Arkansas (City, town, or county) (State or foreign country)  
14. Maiden name Iva Mitchell  
15. Birthplace. Unknown - Arkansas (City, town, or county) (State or foreign country)

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

16. (a) Informant Naymon Baker  
(b) Address 1706 No. 11th St.,  
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/2/45  
(Month) (Day) (Year)  
(c) Place: burial or cremation Forest Home, Arkansas.  
18. (a) Signature of funeral director Albert H. Hoppe  
(b) Address 4700 Washington Blvd.  
19. (a) FEB 2 1945 (Date received local registrar) (b) [Signature] (Registrar's signature)

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) Signs of injury.....  
23. Signature [Signature] (M. B. number) MD  
Address 1515 Lafayette Date signed 2/2/45

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

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**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.....

.....  
working under my personal supervision.

Registered Apprentice No.....

Signed.....

Licensed Embalmer No. *1861*

P. O. Address.....

**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.**