

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

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENTRAL REGISTER

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

5051

FILED FEB 17 1945

State File No.

646

Registration District No. 149

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:
2024 Lister
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution no
(Specify whether
 In this community 3 mo.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Jackson
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL")
 (d) Street No. 2024 Lister
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country no

3. (a) PRINT FULL NAME Henry E. Baker
 3. (b) If veteran, name war no
 3. (c) Social Security No. no

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 2 day 8
 year 1945 hour 10:30 minute a M.

4. Sex male 5. Color or race white
 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Grace Reed Baker
 6. (c) Age of husband or wife if alive 44 years
 7. Birth date of deceased 10/24/1894
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 19 to 19 that I last saw h Carrou alive on 19 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>50</u>	<u>3</u>	<u>14</u>	hr. min.

Immediate cause of death suicide

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

Due to Carbolic acid (phenol)
 Due to 163-85

10. Usual occupation Salesman

Other conditions no
(Include pregnancy within 3 months of death)

11. Industry or business

Major findings: History & Inspection
 Of operations no
 Of autopsy no

MOTHER FATHER

12. Name John Baker
 13. Birthplace Ill.
(City, town, or county) (State or foreign country)
 14. Maiden name Amanda Grasham
 15. Birthplace Mo.
(City, town, or county) (State or foreign country)

PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Grace Baker
 (b) Address 2024 Lister
 17. (a) Burial (b) Date thereof 12/10/45
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Mt. Washington

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) suicide
 (b) Date of occurrence 2-8-45
 (c) Where did injury occur? 2024 Lister, K.C., Jackson, Mo
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
In home
(Specify type of place)
 While at work? no (e) Means of injury Phenol

18. (a) Signature of funeral director John P. Sheil
 (b) Address Kansas City, Mo
 19. (a) 2-9-45 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

23. Signature Jamil Walker (M. D. or other) Carrou
 Address 11424 Phipps Bldg Date signed 2-8-45

(Licensed Embalmer's Statement on Reverse Side)

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

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. 3625

P. O. Address K. E. 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.