

FILED NOV 28 1945

Registration District No. 202

Primary Registration District No. 5731

Registrar's No.

1. PLACE OF DEATH:

(a) County Macon
(b) City or town rural Jackson
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1

(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 Sophronia Baker

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

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

6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive 1863 years

7. Birth date of deceased. Dec. 14 (Month) 1863 (Day) (Year)

8. AGE: Years 81 Months 10 Days 1 If less than one day hr. min.

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

10. Usual occupation Retired House wife

11. Industry or business

12. Name William Burton

13. Birthplace Ky (City, town, or county) (State or foreign country)

14. Maiden name Myrtle Brown

15. Birthplace Ky (City, town, or county) (State or foreign country)

16. (a) Informant Willie Baker

(b) Address Atlanta Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-16-45 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Labor Cem.

18. (a) Signature of funeral director Stephens & Gooding

(b) Address Macon Mo

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon
(c) City or town rural
(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 Oct. day 15 year 1945 hour 2 minute 30 P.M.

21. I hereby certify that I attended the deceased from Oct 15 1945 to Oct 15 1945

that I last saw a alive on Oct 15 1945 and that death occurred on the date and hour stated above.

Immediate cause of death

Cerebral apoplexy Duration 30 min.
arterial Hypertension 5 yrs

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) Means of injury

23. Signature D. L. Harlan (M. D. or other) MD
Address Clearance Mo Date signed Oct 1945

RECEIVED

District Health Officer No. 10

District File Number 11-45-1693

Date Filed NOV-24-1945

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:

working under my personal supervision.

Registered Apprentice No.

Signed

C. L. Stephens

Licensed Embalmer No.

3057

P. O. Address

Macon, 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. 203

Primary Registration District No. 5735

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County macon
(b) City or town macon
(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

Sophronia 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 wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Dec 14 1885
(Month) (Day) (Year)

8. AGE: Years 81 Months 1 Days 1 If less than one day hr. _____ min. _____

9. Birthplace Wm Burton Ky
(City, town or county) (State or foreign country)

10. Usual occupation Wm Burton

11. Industry or business _____

12. Name Wm Burton

13. Birthplace Wm Burton Ky
(City, town, or county) (State or foreign country)

14. Maiden name Wm Burton

15. Birthplace Wm Burton Ky
(City, town, or county) (State or foreign country)

16. (a) Informant Willie Baker

- (b) Address Atlanta, Mo.

17. (a) _____ (b) Date thereof 10-16-48
(Burial, cremation, or otherwise) (Month) (Day) (Year)

- (c) Place: burial or cremation mt Zabar

18. (a) Signature of funeral director Stephens & Dooden

- (b) Address macon, Mo

19. (a) 11-24-46 (b) Mr. O. B. Truffer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County macon

- (c) City or town macon
(If outside city or town limits, write "RURAL")

- (d) Street No. farm - Jackson Trp Macon Co
(If rural, give location)

- (e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 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 cerebral apoplexy 30 min

Due to arterial hypertension 5 yrs

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 Clarence, Mo (M. D. or other) MD
Address _____ Date signed _____

Supplementary

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

37857