

No. 2  
1-2-43  
5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

16281

State File No.

FILED MAY 27 1946  
Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 384

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Springfield  
(c) Name of hospital or institution: Springfield Baptist Hospital  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene  
(c) City or town Springfield  
(If outside city or town limits, write "RURAL")  
(d) Street No. 642 New St.  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Fern Viola Baker

(b) If veteran, name war None (c) Social Security No. UNK.

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

(b) Name of husband or wife None 6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased Dec. 21, 1913  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<u>32</u>	<u>4</u>	<u>13</u>	hr. _____ min. <u>0</u>

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

10. Usual occupation Nurse

11. Industry or business \_\_\_\_\_

12. Name Robert Baker

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

14. Maiden name Weltha Ghan

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

16. (a) Informant Robert Baker  
(b) Address 642 New New, Springfield, Mo.

17. (a) burial (b) Date thereof May, 5, 46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wise Hill

18. (a) Signature of funeral director T.W. Maples

(b) Address Cleaver, Mo.

19. (a) 5-4-46 (b) C. E. Fuller  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 4  
year 1946 hour 3:45 minute A. M.

21. I hereby certify that I attended the deceased from 4-30, 1946, to 5-4, 1946  
that I last saw her alive on 5-3, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute nephritis with coma  
Duration 1 wk

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings:  
Of operations NO  
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 C. E. Fuller (M. D. or other) \_\_\_\_\_  
Address Springfield, Mo. Date signed 5-4-46

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

15168

MAR 31 1955

MAR 1 1955

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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, ~~.....~~.....

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed J. W. Maples

Licensed Embalmer No. 2985

P. O. Address Clever 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.

X