

No. 2
5-42
17-39
X32873

FILED JUN 24 1946

State File No. _____

Registration District No. 22

Primary Registration District No. 30175

Registrar's No. 202

1. PLACE OF DEATH:

(a) County COOPER
(b) City or town LAMINE - RURAL
(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 15 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cooper
(c) City or town Lamine
(If outside city or town limits, write "RURAL")
(d) Street No. Rural (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME AUBURN. C. BAKER

3. (b) If veteran, name war WORLD WAR I 3. (c) Social Security No. 702-14-4715

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED

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

7. Birth date of deceased AUG - 31 - 1886
(Month) (Day) (Year)

8. AGE: Years 59 Months 9 Days 1 If less than one day _____ hr. _____ min.

9. Birthplace COOPER COUNTY MO
(City, town, or county) (State or foreign country)

10. Usual occupation SECTION HAND

11. Industry or business MO PAC. RAILROAD

12. Name WILLIAM BAKER

13. Birthplace HOWARD COUNTY MO
(City, town, or county) (State or foreign country)

14. Maiden name MARTHA BROWN

15. Birthplace HOWARD COUNTY MO
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. JOHN L. DAVIS

(b) Address BOONVILLE MO

17. (a) BURIAL (b) Date thereof JUNE 2 - 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LAMINE CEMETERY

18. (a) Signature of funeral director Goodman & Daller

(b) Address Boonville Mo

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 1st
year 1946 hour about 6 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;

that I last saw him alive on 6/1/46 at 4 P.M. and that death occurred on the date and how stated above.

Immediate cause of death accidental drowning Duration _____

Due to Falling from boat while fishing in Lamine River
Due to _____

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accidental

(b) Date of occurrence June - 1st - 1946

(c) Where did injury occur? on Lamine River near Lamine (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? No (Specify type of place) _____

23. Signature P.M. Floyd _____

Address Boonville Mo Date signed 6/2/46

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 6-19-46

DEC 2 1946

mail

DEC 6 1946

DEC 2 1946

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 J. H. Goodman

Licensed Embalmer No. 1178

P. O. Address Boonville 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. July
2020
Registrar's No.

Registration District No. 82

Primary Registration District No. 5310

1. PLACE OF DEATH:

(a) County Cooper

(b) City or town Rural
(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 Auburn C. Baker

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m

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 Aug 3
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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 _____
(Burial, cremation, or removal) (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 _____ Day _____
Year 1946 (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 _____

Duration

Due to _____

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)
(e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

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

AUG 29 1945

DEC 2 1945

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