

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS
FILED NOV 26 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37530

Registration District No. 169

Primary Registration District No. 4262

Registrar's No. 76

1. PLACE OF DEATH:

(a) County Knox
(b) City or town Knox City
(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. 16 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME George Byron Baxter
3. (b) If veteran, ✓ name war ✓
3. (c) Social Security No. —

4. Sex MO 5. Color or race W
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Katie Jane Baxter
6. (c) Age of husband or wife if alive 31 years 1861 (Day) (Year)
7. Birth date of deceased Aug 31 1861 (Month) (Day) (Year)

8. AGE: Years 85 Months 2 Days 12 If less than one day — hr. — min. —

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

10. Usual occupation Carpenter

11. Industry or business.

MOTHER FATHER { 12. Name BENJAMIN BAXTER
13. Birthplace Mo (City, town, or county) (State or foreign country)
14. Maiden name SARAH SULLIVAN (City, town, or county) (State or foreign country)
15. Birthplace Mo (City, town, or county) (State or foreign country)

16. (a) Informant Byron Baxter
(b) Address Kansas City, Kan.

17. (a) BURIAL (b) Date thereof 11-15-1946 (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation Knox City, Mo.

18. (a) Signature of funeral director C. E. Kupper
(b) Address Clarence, Mo.

19. (a) Nov. 12-46 (b) Will S. Hunsant (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Knox 32
(c) City or town Knox City 0
(If outside city or town limits, write "RURAL")
(d) Street No. — (If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 13
year 1946 hour 7 minute 30A M.

21. I hereby certify that I attended the deceased from Oct 2
1946 to Nov 13 19 46
that I last saw him alive on Nov 12 19 46
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia Duration 2 days

Due to Chronic Myocarditis ?

Due to Chronic Nephritis

Other conditions Chronic Nephritis
(Include pregnancy within 3 months of death)

Major findings:
Of operations 12/13

Of autopsy 12/13

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)
Nalds B. Brown road

23. Signature Nalds B. Brown (M.D. or other)
Address Knox City, Mo Date signed 11/15/46

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

RECEIVED
District Health Officer No. 10
District File Number - 10-46-2135
Date Filed - NOV-25-1946

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.....

Licensed Embalmer No. 426

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.