

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 14 1947
Registration District No. 346

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 43259
Registrar's No. 55

Primary Registration District No. 6165

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD
42068

1. PLACE OF DEATH:
(a) County Stone
(b) City or town rural - Hurley
(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. 1
In this community 26 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Stone 104
(c) City or town Hurley
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mrs. Margaret Baker
3. (b) If veteran, name war.
3. (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov day 2nd
year 1946 hour 5 minute A M.

4. Sex Female 5. Color or race white
6. (a) Single, widowed, married, divorced, wid.
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Dec. 11 - 1869
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1938 to Nov - 2, 1946
that I last saw her alive on Nov - 1, 1946
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
76 10 21 hr. min.

Immediate cause of death
Diphtheria - Chronic
Duration
Years

9. Birthplace Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business

MOTHER FATHER
12. Name unknown 9
13. Birthplace unknown
(City, town, or county) (State or foreign country)
14. Maiden name unknown 7
15. Birthplace unknown
(City, town, or county) (State or foreign country)

Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: 131B
Of operations
Of autopsy

16. (a) Informant Clovis Baker
(b) Address Crane - R-2 - Mo.

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

17. (a) Burial (b) Date thereof 11-7-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Ridge

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?

18. (a) Signature of funeral director J. W. Maples
(b) Address Clever Mo

While at work? (Specify type of place) (e) Means of injury
23. Signature (M. D. or other)
Address Union, Mo Date signed 11-5-46

19. (a) 11-8-46 (b) [Signature]
(Date received local registrar) (Registrar's signature)

RECEIVED
District Health Officer No. R
District No. 147-86
Date Filed JAN 10 1947

2-07
-3-M
-EX 1

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.W. Maple
Licensed Embalmer No. 2985
P. O. Address Claver 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.

B
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3880

State File No. Jan.
Registrar's No. 55

Registration District No. 346

Primary Registration District No. 6165

1. PLACE OF DEATH: Stone
 (a) County Stone
 (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 Margaret 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 WIDOW
 6. (b) Name of husband or wife Charles Wesley Baker
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Dec 11
 (Month) (Day) (Year)

8. AGE: Years 76 Months _____ Days _____
 If less than one day _____ hr. _____ min.

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

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 194 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 _____

Due to _____

Other conditions _____
 (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) _____
 (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 _____

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

SUPPLEMENTARY

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

S-43259