DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 13 1947

Registration District No. 100

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 669

Primary Registration District No. 6387

Registrar's No. 8

1. PLACE OF DEATH:

(a) County DENT

(b) City or town OLA MX
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: NONE
(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 MISSOURI (b) County DENT 32

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

(d) Street No. NEAR GREELEY, MO
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country ____

3. (a) PRINT FULL NAME TOM E. 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 M

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

7. Birth date of deceased SEPT (Month) 22 (Day) 1881 (Year)

8. AGE: Years 65 | Months 3 | Days 19 | If less than one day ____ hr. ____ min.

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

10. Usual occupation FARMER

11. Industry or business ____

MOTHER FATHER

12. Name JOE BAKER

13. Birthplace NO RECORD (City, town, or county) ? (State or foreign country)

14. Maiden name FRANCIS BAKER

15. Birthplace NO RECORD (City, town, or county) ? (State or foreign country)

16. (a) Informant Opal Baker

(b) Address GREELEY, MO

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1-12-47 (Month) (Day) (Year)

(c) Place: burial or cremation GREELEY, MO

18. (a) Signature of funeral director Carl T. Spencer

(b) Address SALEM, MO

19. (a) 1-27-47 (Date received local registrar) (b) M. M. Hart M.D by BB (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 11 year 1947 hour 4:00 minute A. M.

21. I hereby certify that I attended the deceased from 3/14/44 to 1/10/47 that I last saw him alive on 1/10/47 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Myocarditis	unknown
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? (Specify type of place)

While at work? ____ (e) Means of injury ____

23. Signature L. H. Hunt M.D (M. D. or other)

Address Salem, Mo. Date signed 1/12/47

83 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 24755
Date Filed 2-10-47

JUN 11 1947

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 Wm. W. McDonald

Licensed Embalmer No. 3806

P. O. Address Salem, Ore

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. 7-A

Registration District No. 100 Primary Registration District No. 5387 Registrar's No. 8

1. PLACE OF DEATH:

(a) County Dent

(b) City or town Rural No Iron Mo
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME Tom E. 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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept (Month) 22 (Day) 88 (Year)

8. AGE: Years 65 | Months 3 | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day
year 1967 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

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

S-6669