

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14136

State File No.

FILED MAY 5 1947  
Registration District No. 4-1947-201

Primary Registration District No. 201 4315

Registrar's No.

1. PLACE OF DEATH:

(a) County Macou  
(b) City or town Lallate  
(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 88 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME

James L. Baldon

3. (b) If veteran name war 1 3. (c) Social Security No. 1

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife 1 6. (c) Age of husband or wife if alive 20 years (Month) (Day) (Year)  
7. Birth date of deceased Oct 20 1958 (Month) (Day) (Year)

8. AGE: Years 88 Months 6 Days 21 If less than one day hr. min. 0

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

10. Usual occupation House Keeper

11. Industry or business

12. Name James Baldon  
13. Birthplace Indiana (City, town, or county) (State or foreign country)  
14. Maiden name Margaret Cortes  
15. Birthplace Indiana (City, town, or county) (State or foreign country)

16. (a) Informant Wesley Baldon  
(b) Address Lallate Mo

17. (a) Burial (b) Date thereof 4-12-1947 (Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Lallate

18. (a) Signature of funeral director A. Christie  
(b) Address Lallate Mo

19. (a) Apr 16 47 (b) Mo O B Grepper (Date received local registry) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macou  
(c) City or town Lallate (If outside city or town limits, write "RURAL")  
(d) Street No. 1 (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 10 year 1947 hour 1 minute 2 M.

21. I hereby certify that I attended the deceased from Mar 21 1947 to Apr 4 1947. that I last saw him alive on Apr 4 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Nephritis Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 1318

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 0

23. Signature C. H. Grepper (M. D. or other) Address Lallate Mo Date signed 4-12-47

RECEIVED  
District Health Officer No. 10  
District File Number 4-47-252  
Date filed MAY - 21 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

*D. S. Christie*

Licensed Embalmer No.

1109

P. O. Address

*La Plata 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.