

FILED AUG 18 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

28520

Registration District No. 270

Primary Registration District No. 3050

Registrar's No. 50

1. PLACE OF DEATH:

(a) County Pemiscot

(b) City or town Caruthersville

(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 about 30 years. (Specify whether years, months or days)

3. (a) PRINT FULL NAME John Henry Baldwin

3. (b) If veteran name war ✓

3. (c) Social Security No. Don't know

4. Sex M 2. Color or race negro

6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Unknown

8. AGE: Years about 78 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Chickasaw Miss!

10. Usual occupation Brick mason

11. Industry or business _____

MOTHER FATHER { 12. Name Unknown 9

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 Franela

(b) Address _____

17. (a) Burial (b) Date thereof 8-3-1947

(c) Place: burial or cremation Morgan Aulog

18. (a) Signature of funeral director L. G. House Int. Co.

(b) Address Caruthersville, Mo.

19. (a) 8-14-47 (b) Fessie B. Wilks

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pemiscot 78

(c) City or town Caruthersville 1
(If outside city or town limits, write "RURAL") 2

(d) Street No. _____ (If rural, give location) 0

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 1 year 1947 hour 7 minute 06 P. M.

21. I hereby certify that I attended the deceased from Aug. 1, 1947 to Aug. 1, 1947, 19____ that I last saw him alive on Aug. 1, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Apparently died from mal nutrition.

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: 200

Of operations _____

Of autopsy _____

Duration _____

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)

(c) Means of injury _____

23. Signature J. W. Phipps (M. D. or other) _____

Address Caruthersville, Mo. Date signed 8/5/47

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

18
1
2

8-47-234

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..... *Noel C Deau*

Licensed Embalmer No..... *3971*

P. O. Address..... *Carrithersville*

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.