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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 19 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31735

State File No. _____

Registration District No. 184

Primary Registration District No. 3038

Registrar's No. 68

1. PLACE OF DEATH

(a) County Linn
(b) City or town Brookfield
(If outside city or town limits write "RURAL" and name of township)
(c) Name of hospital or institution: 120 G. Canal
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 16 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Linn
(c) City or town Brookfield
(If outside city or town limits, write "RURAL")
(d) Street No. 120 G. Canal
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JAMES MORRIS 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 Divorced
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec - 29 - 1870
(Month) (Day) (Year)

8. AGE: Years 76 Months 7 Days 24 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired P.R. Section Hand

11. Industry or business _____

12. Name Robert J. Baker

13. Birthplace D.K. Ind
(City, town, or county) (State or foreign country)

14. Maiden name Nancy Thomas

15. Birthplace Durley Co. Ky
(City, town, or county) (State or foreign country)

16. (a) Informant Mollie Sullivan

(b) Address Brookfield Mo

17. (a) Burial (b) Date thereof Aug - 24 - 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rose Hill Cemetery

18. (a) Signature of funeral director Will Funeral Home

(b) Address Brookfield Mo

19. (a) 9-8-47 (b) Walter Berwin
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 22 year 1947 hour 7 minute 20 P.M.

21. I hereby certify that I attended the deceased from Oct 17 to Aug 20, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis Duration _____

Due to arterio sclerosis cerebral + general

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

Major findings: Of operations gastro 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:

(c) Accident, suicide, or homicide (specify) _____ (b) Date of occurrence _____

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 Ray R. Baker (M. D. or other) M.D. Address Brookfield Mo Date signed 9-1-47

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

MOTHER FATHER

**DISTRICT HEALTH OFFICE
Cameron, Mo.**

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. L. Blacklock

Licensed Embalmer No. *2246*

P. O. Address *Brookfield 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.