S. No. 2
1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

FILED NOV 3 1947

Registration District No. 318

Primary Registration District No. 1003

State File No. 35480

Registrar's No. 9732

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Enroute to City Hospital 0
(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 00-0

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 1810 LaSalle Avenue, 9
22 (If rural, give location) 0

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

If yes, name country

3. (a) PRINT FULL NAME Frank B. Baker

3. (b) If veteran, name war Unknown

3. (c) Social Security No. Unknown

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife Unknown

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

7. Birth date of deceased August (Month) 3 (Day) 1900 (Year)

8. AGE:

Years	Months	Days	If less than one day
47	2	16	hr. min.

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

10. Usual occupation Labourer

11. Industry or business

FATHER
12. Name Adam Jesse Baker
13. Birthplace Osage County (City, town, or county) Missouri (State or foreign country) 0

MOTHER
14. Maiden name Lulu May Miller
15. Birthplace Linn (City, town, or county) Missouri (State or foreign country) 0

16. (a) Informant Mrs. Hugh Reymolds
(b) Address Linn, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/47 (Month) (Day) (Year)
(c) Place: burial or cremation Linn, Missouri

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address OCT 20 1947 700 Washington Blvd.,

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 19
year 1947 hour 4 minute 30 a M.

21. I hereby certify that I attended the deceased from
2 19 to 19
that I last saw h alive on 19
and that death occurred on the date and hour stated above.

Immediate cause of death: Internal Hemorrhage from stab wound of one Clifford Nathaniel Ford at the corner of Mississippi & La Salle Streets Mound 1206 A.M. Oct 19, 1947

Due to: When he was attacked by Joseph Baker and the deceased Frank Baker

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations 1108
Of autopsy

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Instrumental Homicide
(b) Date of occurrence Oct. 19, 1947
(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? Public Street (Specify type of place)
While at work? (e) Means of injury by [illegible]

23. Signature Patrick E. Taylor (M. D. or other) 3
Address Dep. Coroner Date signed 10/20/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

MAR 3 1948

NOV 3 1947

APR 9 1957

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. Allen Dauer

Licensed Embalmer No. 4055

P. O. Address St Louis 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.

S. No. 2B
25M—3-45
1 X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Nor

Registration District No. 314 Primary Registration District No. 1003 Registrar's No. 9732

1. PLACE OF DEATH:

(a) County
(b) City or town ST. LOUIS
(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 Frank B. 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 Div

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug. (Month) 3 (Day) 1899 (Year)

8. AGE: Years 47 Months 2 Days If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) J. F. Brenneck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day year 1947 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.

Immediate cause of death — Duration

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

S-35480