

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 9 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31904
Registrar's No. 162

Registration District No. 10

Primary Registration District No. 3002

1. PLACE OF DEATH:

(a) County Andrain
(b) City or town Mexico
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Andrain County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days (Specify whether
In this community, years, months or days)

3. (a) PRINT FULL NAME

Nellie Bell Baker

3. (b) If veteran,

name war no

3. (c) Social Security

No. 493-38-7907

4. Sex Female

5. Color or race Negro

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

6. (b) Name of husband Mark Baker

6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased 12 March 1896
(Month) (Day) (Year)

8. AGE:

Years 52 Months 7 Days 16

If less than one day

hr. min.

9. Birthplace Callaway Co Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business

12. Name Will Galbreth
13. Birthplace Callaway Co Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Abba White
15. Birthplace Callaway Co Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Frank Galbreth

(b) Address Anyvasse Missouri

17. (a) Removal (b) Date thereof Oct 31-1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Anyvasse Mo

18. (a) Signature of funeral director Walter O. Parker

(b) Address Columbia Missouri

19. (a) 10/31/48 (b) B. Plante Neely
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrain
(c) City or town Mexico
(If outside city or town limits, write "RURAL")
(d) Street No. 801 East Bolivar
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 28th
year 1 hour 15 minute P M.

21. I hereby certify that I attended the deceased from 10
24, 1948, to 10-28, 1948
that I last saw her alive on 10-28, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic hepatitis
sangocarditis
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?

While at work?

(Specify type of place)

(c) Means of injury

23. Signature H. J. Lelton (M. D. or other)
Address Mexico Mo Date signed 10/29/48

RECEIVED

District Health Officer No. 1

District File Number 11-48-190

Date Filed NOV 8 - 1948

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~~

working under my personal supervision.

Registered Apprentice No.

Signed

Licensed Embalmer No.

P. O. Address

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.