

FILED NOV 18 1948

Registration District No. 200

Primary Registration District No. 57-25

State File No.

Registrar's No. 399

1. PLACE OF DEATH:

(a) County Macdon
(b) City or town Macdon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Still-Hill Health Osteopathic San.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Four days
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME Clas. Hugh Baker

3. (b) If veteran,
name war

3. (c) Social Security
No. 236-16-9030

4. Sex Male 5. Color or
race White

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

6. (b) Name of husband or wife
1913, 1918

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

7. Birth date of deceased Nov. 26 1916
(Month) (Day) (Year)

8. AGE: Years 31 Months 10 Days 19

If less than one day
hr. min.

9. Birthplace Wallace
(City, town, or county)

West Va.
(State or foreign country)

10. Usual occupation

11. Industry or business

Farmer

12. Name Foster H. Baker

13. Birthplace West Va.
(City, town, or county)

West Va.
(State or foreign country)

14. Maiden name Bessie Hill

15. Birthplace West Va.
(City, town, or county)

West Va.
(State or foreign country)

16. (a) Informant Foster H. Baker

(b) Address Wallace, West Va. R.R. 3

17. (a) removal (b) Date thereof Oct. 15, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Robinson Cem. Harrison Co.

18. (a) Signature of funeral director Alfred J. ...

(b) Address Macdon, Missouri

19. (a) 11-6-48 (b) With McNeely
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State West Va. (b) County Harrison
(c) City or town Wallace Rural
(If outside city or town limits, write "RURAL")
(d) Street No. R.F.D. #3
(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 15
year 1948 hour 4 minute 00 A.M.

21. I hereby certify that I attended the deceased from Oct. 11
1948 to Oct. 15, 1948;
that I last saw him alive on Oct. 15, 1948;
and that death occurred on the date and hour stated above.

Immediate cause of death Influenza

Schizophrenic
condition of ten yrs.
standing

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

Major findings:
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 2

23. Signature Eldon A. Meryew (or other) D.O.
Address S.H.C.S. Macdon, Mo. Date signed 11-15-48

RECEIVED

District Health Officer No. 10

District File Number 11-48-1472

NOV 17 1948

San Francisco

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.....

Albert Skinner

Licensed Embalmer No. 781

P. O. Address Maen MA

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1000

Registration District No. 200

Primary Registration District No. 5725

Registrar's No. 399

1. PLACE OF DEATH:

- (a) County Macou
(b) City or town Macou
(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

In this community years, months or days)

3. (a) PRINT FULL NAME

Chas. H. 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

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

7. Birth date of deceased Nov. 26 (Month) (Day) (Year)

8. AGE: Years 31 Months 10 Days 10 (If less than one day, hr. min.)

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

10. Usual occupation

11. Industry or business

12. Name Farmer
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

- (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) (Registrar's signature)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov year 1948 hour 10 minute 00 M.

21. I hereby certify that I attended the deceased from to, 19

that I last saw him alive on, 19

and that death occurred on the date and hour stated above. Immediate cause of death

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 (M. D. or other)

Address Date signed

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

SUPPLEMENTARY

5-37312