

FILED APR 20 1949

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

11681

State File No.

| | | | | |
|--|--|---|---|---|
| BIRTH NO. _____ | | REG. DIST. NO. <u>47</u> | PRIMARY REG. DIST. NO. <u>3008</u> | Registrar's No. <u>114</u> |
| 1. PLACE OF DEATH a. COUNTY <u>CALLAWAY</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>PIKE</u> c. CITY (If outside corporate limits, write RURAL and give township) <u>BOWLING GREEN</u> d. STREET ADDRESS (If rural, give location) <u>1505 CORTE MARIAL AVE 1</u> | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>FULTON</u> | | c. LENGTH OF STAY (in this place) <u>7 1/2</u> days | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>STATE HOSPITAL No. 12</u> | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>NANNIE</u> b. (Middle) <u>JANE</u> c. (Last) <u>BAKER</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL 10 1949</u> | | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOW</u> | 8. DATE OF BIRTH <u>MAY 26 1865</u> | 9. AGE (In years last birthday) <u>83</u> IF UNDER 1 YEAR Months <u>10</u> Days <u>14</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOSE KEEPING</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u> | 11. BIRTHPLACE (State or foreign country) <u>JACKSON COUNTY KENTUCKY</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u> |
| 13a. FATHER'S NAME <u>MITCHELL POWELL</u> | | 13b. MOTHER'S MAIDEN NAME <u>SALLIE ?</u> | | 14. NAME OF HUSBAND OR WIFE <u>Mr. BAKER</u> |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>Unknown</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | | 17. INFORMANT'S SIGNATURE OR NAME <u>STATE HOSPITAL No. 1</u> ADDRESS <u>FULTON, MO.</u> |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>acute insufficiency and stenosis Myocardium Mild cardiac decompensation</u> | | INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION <u>None</u> | 19b. MAJOR FINDINGS OF OPERATION <u>None</u> | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u> | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u> | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>None</u> | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u> | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? <u>None</u> | | |
| 22. I hereby certify that I attended the deceased from <u>25 Sept</u> , 19 <u>48</u> , to <u>10 April</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>10 April</u> , 19 <u>49</u> , and that death occurred at <u>9:30 Am.</u> , from the causes and on the date stated above. | | | | |
| 23a. SIGNATURE (Degree or title) <u>M. J. Miller</u> | | 23b. ADDRESS <u>Fulton Missouri</u> | | 23c. DATE SIGNED <u>10 April 49</u> |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>4-12-49</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Caryville, Mo.</u> | 24d. LOCATION (City, town, or county) (State) <u>Caryville, Mo.</u> | |
| DATE REC'D BY LOCAL REG. <u>April-10-1949</u> | REGISTRAR'S SIGNATURE <u>Maretta Lawrence</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Grace Bankhead Bowling Green</u> ADDRESS _____ | | |

(Licensed Embalmer's Statement on Reverse Side)

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

Date Filed APR 19 1949
District File Number

District Health Officer No. 9

RECEIVED

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.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed Harold C. K. Mike

Licensed Embalmer No. 4597

P. O. Address Bowling Green, 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.