

FILED APR 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13568

#90208

318

1003

State File No. _____
Registrar's No. 3420

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Mo.</u>		c. LENGTH OF STAY (In this place) <u>4 days</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Mo.</u>		07/7
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis City Hospital #1.</u>			d. STREET ADDRESS (If rural, give location) <u>1410 N. 20 St.</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>MARY</u>		b. (Middle) _____		c. (Last) <u>BAKER</u>	
4. DATE OF DEATH <u>March 8th, 1949</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Child</u>		8. DATE OF BIRTH <u>2/15-1945</u>		9. AGE (In years last birthday) <u>4</u> 10. IF UNDER 1 YEAR Months <u>0</u> Days <u>21</u> 11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Blytheville, Ark!</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Earl Baker</u>		13b. MOTHER'S MAIDEN NAME <u>Connie Aeldine</u>	
14. NAME OF HUSBAND OR WIFE <u>Child</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Connie Baker States</u>		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>no</u>		19. ADDRESS _____	
18. CAUSE OF DEATH (Continued) *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>Tuberculosis of Lungs, In Ad. Sep 48</u>			INTERVAL BETWEEN ONSET AND DEATH <u>13.5</u>		
ANTECEDENT CAUSES Morbidity 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>Tuberculosis adenitis</u>		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <u>3/6/48</u> , 19 <u>48</u> , to <u>3/8/49</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>3/8/49</u> , 19 <u>49</u> , and that death occurred at <u>3:00AM</u> from the causes and on the date stated above.					
23a. SIGNATURE <u>Joseph E. Elden MD.</u>		23b. ADDRESS <u>1515 Lafayette Ave.,</u>		23c. DATE SIGNED <u>3/8/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>3/10/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>New Malden</u>	
24d. LOCATION (City, town, or county) (State) <u>Malden, Mo</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Floyd Russell</u>		ADDRESS _____	
DATE REC'D BY LOCAL REG. <u>APR 15 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Sasitar</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Floyd Russell</u>	

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

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.

Signed.....

Signed.....
Student Embalmer

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.