

FILED MAY 12 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

14005

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| BIRTH NO. _____ | | REG. DIST. NO. <u>274</u> | | PRIMARY REG. DIST. NO. <u>3052</u> | | Registrar's No. <u>169</u> | |
| 1. PLACE OF DEATH a. COUNTY <u>PETTIS</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>PETTIS</u> | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SEDALIA</u> | | | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SEDALIA</u> <u>0804</u> | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>514A SOUTH KENTUCKY</u> | | | | d. STREET ADDRESS (If rural, give location) <u>514 A SOUTH KENTUCKY</u> | | | |
| 3. NAME OF DECEASED (Type or Print) <u>ALLIE</u> | | a. (First) <u>M</u> | | c. (Last) <u>Baker</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>4-28-1950</u> | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> <u>2</u> | | 8. DATE OF BIRTH <u>Mar. 16, 1885</u> | |
| 9. AGE (In years last birthday) <u>65</u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Sedalia, Mo</u> <u>D</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13a. FATHER'S NAME <u>W.M. Pope</u> | | 13b. MOTHER'S MAIDEN NAME <u>Sarah Latsch</u> | | 14. NAME OF HUSBAND OR WIFE <u>Geo. Baker</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>494-30-9921</u> | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Maxine Fullerton, Sedalia, 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, asphyxia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Uremic Encephalopathy</u> <u>Convulsions</u> <u>4 Days</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Uremic Poisoning</u> DUE TO (c) <u>(Acute Nephritis) suprapurulent</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Uremia</u> <u>Poorly Nourished</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 Days</u> | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) m. | | 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>4-28</u> , 1950, to <u>4-28</u> , 1950, that I last saw the deceased alive on <u>4-28</u> , 1950, and that death occurred at <u>2:15 P.m.</u> , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Degree or title) <u>Frank P. Kucy</u> <u>O.M.D.</u> | | 23b. ADDRESS <u>Sedalia, Mo</u> | | 23c. DATE SIGNED <u>4-28-50</u> | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>May 1, 1950</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill Cemetery</u> | | 24d. LOCATION (City, town, or county) (State) <u>Sedalia, Mo</u> | |
| DATE REC'D BY LOCAL REG. <u>5-1-1950</u> | | REGISTRAR'S SIGNATURE <u>W. C. Hall</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. Hall</u> | | ADDRESS <u>Sedalia, Mo.</u> | |

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

MAY 9

District Health Officer No. 8,

District File Number.....

Date Filed 5/9/50

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.....

Alvo Beckert

Licensed Embalmer No.

3470

P. O. Address.....

Indianapolis, 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.