

FILED FEB 12 1951

THE DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **194**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **111**

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Dickell</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St Joseph</b>	c. LENGTH OF STAY (In this place) <b>2 yrs. 10 m. 20 d.</b>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Maysville</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>State Hospital No 2</b>		d. STREET ADDRESS (If rural, give location) <b>Courtesy Farm</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Lois</b> b. (Middle) _____ c. (Last) <b>Baker</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Feb 3 1951</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>never married</b>	8. DATE OF BIRTH <b>Feb. 28 1901</b>	9. AGE (In years last birthday) <b>49</b>	IF UNDER 1 YEAR Months <b>11</b> Days <b>15</b>	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (State or foreign country) <b>Missouri 0</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	

13a. FATHER'S NAME <b>not known</b>	13b. MOTHER'S MAIDEN NAME <b>not known</b>	14. NAME OF HUSBAND OR WIFE <b>✓</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE AND NAME ADDRESS <b>Mrs. Belle McCaskey Amity Mo</b>

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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Hypostatic Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Chronic myocarditis</b>		
	DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<b>42220</b>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" 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 **Jan 1**, 1951, to **Feb 3**, 1951, that I last saw the deceased alive on **Feb 2**, 1951, and that death occurred at **12:00 A. M.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Forrest Thomas M.D.</b>	23b. ADDRESS <b>St Joseph State Hospital No 2 Mo</b>	23c. DATE SIGNED <b>2/3-1951</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <b>2/3-51</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Amity</b>	24d. LOCATION (City, town, or county) (State) <b>Amity Mo</b>
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DATE REC'D BY LOCAL REG. <b>Feb. 6, 1951</b>	REGISTRAR'S SIGNATURE <b>Carl P. Casper</b>	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <b>Edwin Thomas Amity Mo</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

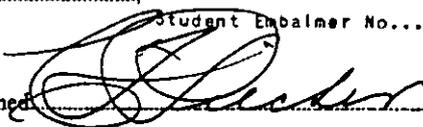
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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate <sup>will be</sup> ~~was~~ embalmed by me, or by \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed  \_\_\_\_\_

Signed.....  
Student Embalmer

Licensed Embalmer No. 3960

P. O. Address Maple Md

**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.