

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **44248**

S. No. 300
V. 10.48

DEC 29 1952

BIRTH NO. _____ REG. DIST. NO. **340** PRIMARY REG. DIST. NO. **6151** Registrar's No. **88**

1. PLACE OF DEATH a. COUNTY Stoddard		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Stoddard	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Essex Elk Twp.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Essex Elk Twp. 1030	
c. LENGTH OF STAY (in this place) 04 yrs.		d. STREET ADDRESS (If rural, give location) Route 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION Route 1		d. STREET ADDRESS (If rural, give location) Route 1	

3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) Katherine c. (Last) Baker			4. DATE OF DEATH (Month) (Day) (Year) Dec. 10, 1952		
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Dec. 3, 1879	9. AGE (In years) (last birthday) 73	# UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY housekeeper		11. BIRTHPLACE (City and State or Foreign Country) Williamson Co. Ill.	
13a. FATHER'S NAME William Warren		13b. MOTHER'S MAIDEN NAME Mary Bradberry		14. NAME OF HUSBAND OR WIFE William Baker	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. X X		17. INFORMANT'S SIGNATURE OR NAME ADDRESS William Baker Essex, Mo. R. 1	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobar Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 7 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) rise to the above cause (a) stating the underlying cause last. — DUE TO (c)		
	11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 490X	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) (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 **Dec 9, 1952** to **only**, 19___, that I last saw the deceased alive on **Dec 9, 1952**, and that death occurred at ___ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) F. K. Lindo		23b. ADDRESS Bernie, Mo.		23c. DATE SIGNED 12-19-52	
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 12-11-52	24c. NAME OF CEMETERY OR CREMATORY Pleasant Valley	24d. LOCATION (City, town, or county) (State) Dexter, Mo. R. 1		
DATE REC'D BY LOCAL REG. 12/26/52	REGISTRAR'S SIGNATURE Velma V. ...	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Watkins Funeral Ser. Dexter, Mo.			

(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 was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Walter Marsh Watkins

Licensed Embalmer No. 4717

P. O. Address Depton, 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.