

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

23358

State File No. ....

FILED JUN 26 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317A PRIMARY REG. DIST. NO. 546 Registrar's No. 1624

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>St. Louis</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>Overland</u>   |  | c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Ann Florissant</u>   |  |
| c. LENGTH OF STAY (In this place) <u>10 Months</u>   |  | d. STREET ADDRESS (If rural, give location) <u>10318 St. Joan Lane 4061</u>  |  |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Overland Restorium</u> |  |  |  |

|                                     |                        |                       |                        |   |
|-------------------------------------|------------------------|-----------------------|------------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>Mary</u> | b. (Middle) <u>M.</u> | c. (Last) <u>Baker</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>June 11 1953</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>July 20 1875</u> | 9. AGE (In years last birthday) <u>77</u> | 10. IF UNDER 1 YEAR Months _____ Days _____ | 11. IF UNDER 24 HRS. Hours _____ Min. _____ |
|----------------------|-------------------------------|---|--------------------------------------|---|---|---|

|  |  |  |  |
|--|--|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u> | 11. BIRTHPLACE (City and State or Foreign Country) <u>St. Peters Mo.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
|--|--|--|--|

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| 13a. FATHER'S NAME <u>George Pfaff</u> | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | 14. NAME OF HUSBAND OR WIFE <u>Archibald Baker</u> |
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|  |                                     |  |                                   |
|--|-------------------------------------|--|-----------------------------------|
| 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>None</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Evelyn Gilder</u> | ADDRESS <u>10318 St. Joan La.</u> |
|--|-------------------------------------|--|-----------------------------------|

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion -</u>   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 day</u> |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Cerebral Hemorrhage -</u> |  |  |
|   | DUE TO (c) <u>Arteriosclerosis -</u>   |  |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |  |  | <u>8 mo.</u><br><u>years.</u>                    |

|                              |  |  |
|------------------------------|--|--|
| 19a. DATE OF OPERATION _____ | 19b. MAJOR FINDINGS OF OPERATION <u>331X</u> | 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) (Min.) _____ | 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 Aug. 2, 1953 to June 11, 1953, that I last saw the deceased alive on 6/11, 1953 and that death occurred at 10:30 p.m., from the causes and on the date stated above.

|  |                                      |                                 |
|--|--------------------------------------|---------------------------------|
| 23a. SIGNATURE (Degree or title) <u>Roy A. Wallace Sr. MD.</u> | 23b. ADDRESS <u>2438 Woodson Rd.</u> | 23c. DATE SIGNED <u>6/13/53</u> |
|--|--------------------------------------|---------------------------------|

|   |                          |  |   |
|---|--------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>6/15/53</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u> | 24d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u> |
|---|--------------------------|--|---|

|   |   |  |                                     |
|---|---|--|-------------------------------------|
| DATE REC'D BY LOCAL REG. <u>6-13-53</u> | REGISTRAR'S SIGNATURE <u>Herbert R. Domb MD</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Collins Funeral Home</u> | ADDRESS <u>10123 St. Charles Rd</u> |
|---|---|--|-------------------------------------|

(Licensed Embalmer's Statement on Reverse Side)

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

044

**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

*Sheldon Collier*

Licensed Embalmer No.

*3382*

P. O. Address

*10123 St. Charles*

**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.