

FILED MAY 21 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHShropshire 17623  
State File No.

BIRTH NO. _____		REG. DIST. NO. 333		PRIMARY REG. DIST. NO. 36115		Registrar's No. 59	
1. PLACE OF DEATH a. COUNTY <u>SCOTT</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MO</u> b. COUNTY <u>SCOTT</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL Richland</u>		c. LENGTH OF STAY (in this place) <u>LIFE</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL Sikeston</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Sikeston. R.I</u>				d. STREET ADDRESS (If rural, give location) <u>SIKESTON R 2 D #1</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>JAMES</u>		b. (Middle) <u>WASHINGTON</u>		c. (Last) <u>BAKER JR</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>5-4-54</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>9-1-1882</u>	
9. AGE (in years last birthday) <u>71</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>			11. BIRTHPLACE (City and State or Foreign Country) <u>SIKESTON MO 0</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>J.W. BAKER SR.</u>		13b. MOTHER'S MAIDEN NAME <u>MARY EUNICE GREEN</u>		14. NAME OF HUSBAND OR WIFE <u>Flora</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>0</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Flora Baker Sikeston 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>Chronic Myocardial failure</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Myocardial Infarct</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS - <u>Conditions contributing to the death but not related to the disease or condition causing death.</u> <u>Pulmonary Edema</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 mo.</u> <u>10 yrs ago</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>4201</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT (Specify) _____ SUICIDE _____ HOMICIDE _____		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>May</u> , 19 <u>53</u> , to <u>4-May</u> , 19 <u>54</u> that I last saw the deceased alive on <u>3-May</u> , 19 <u>54</u> , and that death occurred at <u>8:45 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>H.B. Shropshire, M.D.</u> (Degree or title)				23b. ADDRESS <u>Sikeston, Mo.</u>		23c. DATE SIGNED <u>8-May 54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>5-6-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>City</u>		24d. LOCATION (City, town, or county) (State) <u>SIKESTON MO</u>	
DATE REC'D BY LOCAL REG. <u>5-10-54</u>		REGISTRAR'S SIGNATURE <u>Mrs. G. Hunter</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Welsh Funeral Home - Sikeston Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

DATE RECEIVED MAY 17 1954

SCOTT CO. HEALTH DEPT.

CO. FILE No. 554-95

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 Raymond Grews

Licensed Embalmer No. 3467

P. O. Address Sikeston 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.