

FILED NOV 8 - 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34552

BIRTH NO. _____		REG. DIST. NO. 187		PRIMARY REG. DIST. NO. 3040		Registrar's No. 180	
1. PLACE OF DEATH a. COUNTY--Livingston				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Carroll			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Chillicothe		c. LENGTH OF STAY (In this place) 4 days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hale,		0120 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION Chillicothe Hospital				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM b. (Middle) XX c. (Last) BAKER			4. DATE OF DEATH (Month) (Day) (Year) October 27, 1954				
5. SEX M	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 10, 1867		9. AGE (In years last birthday) 87	10. UNDER 1 YEAR 8 Months	11. UNDER 12 Mths. 17 Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Carroll County, Mo		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Archibald A. Baker			13b. MOTHER'S MAIDEN NAME Mary Jane Norris,		14. NAME OF HUSBAND OR WIFE Mattie Baker,		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mattie Baker, Hale, Mo.			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Chr. Myocarditis</i> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Atherosclerosis</i> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Chr. Myeloid Leukemia</i>					INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 15 yrs.
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4221H			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 7/17/1952 to 10/27/1954, that I last saw the deceased alive on 10/26/1954, and that death occurred at 2: A. m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <i>J. M. Dowell, M.D.</i>				23b. ADDRESS Chillicothe Mo		23c. DATE SIGNED 10/29/54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10/29/1954	24c. NAME OF CEMETERY OR CREMATORY Hale Cemetery		24d. LOCATION (City, town, or county) (State) Hale, Missouri		
DATE REC'D BY LOCAL REG. 10/29/54		REGISTRAR'S SIGNATURE <i>Trancee B. Hall</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Clifford W. Austin Tina, Mo.			

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

Clifford W. Austin

Licensed Embalmer No. 3233

P. O. Address Tina, Missouri

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.