

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

378

State File No.

No. 300

10.48

FILED JAN 10 1955

BIRTH NO. _____ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 1

1. PLACE OF DEATH a. COUNTY <u>Callaway</u> <u>01432</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Fulton</u>		c. CITY OR TOWN <u>Fulton</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>2 MO.</u>		e. STREET ADDRESS (If rural, give location) <u>1016 W. Ave</u> <u>01430</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital #</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Eolene Rebecca</u> b. (Middle) <u>Baker</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 3 1955</u>		
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	
8. DATE OF BIRTH <u>Nov 19 1876</u>		9. AGE (In years last birthday) <u>78</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>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					

13a. FATHER'S NAME <u>William Fox</u>		13b. MOTHER'S MAIDEN NAME <u>Catherine Childs</u>		14. NAME OF HUSBAND OR WIFE <u>R.W. Baker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>State Hospital Records, Fulton, 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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION			

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac Decompensation</u>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u>		<u>Arteriosclerosis</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>Chronic Brain Syndrome associated with Senile Brain disease</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Fracture Hip</u>	
19c. DATE OF OPERATION		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) (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 Oct 20, 1954, to Jan 3, 1955, that I last saw the deceased alive on Jan 3, 1955, and that death occurred at 8:10 P.m., from the causes and on the date stated above.

23a. SIGNATURE <u>J. M. Miller, M.D.</u> (Degree or title)		23b. ADDRESS <u>State Hospital</u>		23c. DATE SIGNED <u>1/3/55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Jan-5-1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Montgomery City Cem.</u>	
24d. LOCATION (City, town, or county) (State) <u>Montgomery City Mo</u>					

DATE REC'D BY LOCAL REG. <u>Jan 3 - 1955</u>		REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u> <u>426</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wallace Funeral Home, Fulton, Mo</u>	
(Licensed Embalmer's Statement on Reverse Side)					

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

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.....
Signature of Student Embalmer

Signed *Denzil O. Browning*.....

Licensed Embalmer No. *272*.....

P. O. Address *Fulton, N.Y.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.