

28641

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 2 1955

State File No.

No. 300
10. 48

BIRTH NO. _____ REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 123

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Scott</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Sikeston</u>		c. LENGTH OF STAY (in this place) <u>Life</u>	c. CITY OR TOWN <u>Sikeston</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mo. Delta Community Hospital</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		STREET ADDRESS (If rural, give location) <u>132 North West St.</u> <u>10230</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>James</u>	b. (Middle) <u>William</u>	c. (Last) <u>Baker</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>8</u> <u>15</u> <u>1955</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1-1-1886</u>
9. AGE (In years last birthday) <u>69</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>Retired</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>0</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Mississippi Co., Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Joe Baker</u>	13b. MOTHER'S MAIDEN NAME <u>Jane Pritchett</u>	14. NAME OF HUSBAND OR WIFE <u>Mary Elizabeth Helton</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>0</u> (If yes, give war or dates of service) <u>0</u>	16. SOCIAL SECURITY NO. <u>0</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Mary Baker, Sikeston, Mo.</u> ADDRESS _____

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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Skull fracture</u>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. 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 _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Hwy 60 West</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Sikeston 141 Scott Mo</u>

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>8 15 1955. 2Pm</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Walked across Hwy. Eas hit by Car.</u>
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22. I hereby certify that I attended the deceased from 8/15, 1955, to 8/15, 1955, that I last saw the deceased alive on 8/15, 1955, and that death occurred at 6:15 P. m., from the causes and on the date stated above.

23a. SIGNATURE <u>Wm. C. Citchlow M.D.</u> (Degree or title) <u>9</u>	23b. ADDRESS <u>Sikeston, Missouri</u>	23c. DATE SIGNED <u>aug 17, 1955</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>8-18-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>DOGWOOD</u>
24d. LOCATION (City, town, or county) (State) <u>Miss. Co. Mo.</u>		

DATE REC'D BY LOCAL REG. <u>8-27-55</u>	REGISTRAR'S SIGNATURE <u>Mrs. Clara Hunter</u> <u>429</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Welch Funeral Home Sikeston Mo.</u> ADDRESS _____
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(Licensed Embalmer's Statement on Reverse Side)

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

DATE RECEIVED AUG 29 1955

SCOTT CO. HEALTH DEPT.

CO. FILE No. 855-188

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 *Lucille Rainey*.....

Licensed Embalmer No. *498*

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