

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43285**
5633

FILED JAN 18 1956

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Kansas b. COUNTY LEAVENWORTH	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. CITY OR TOWN Tonganoxie	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) 1 week		e. STREET ADDRESS (If rural, give location) 815 S.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2537 Olive			

3. NAME OF DECEASED (Type or Print) a. (First) Lee b. (Middle) Onzelworth c. (Last) Baker			4. DATE OF DEATH (Month) (Day) (Year) 12 17 55		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 2/27/93	9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months Days IF UNDER 4 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Leavenworth County Kans	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME Henry Baker	13b. MOTHER'S MAIDEN NAME Millie Freeland	14. NAME OF HUSBAND OR WIFE Bartie Baker
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Theodore Baker ADDRESS Tonganoxie Kans
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Congestive Heart Failure		* ANTECEDENT CAUSES		
* This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) Arteriosclerotic Heart Disease		
		DUE TO (c) Bronchial Asthma		
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"/>
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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) (Minute)	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 9/26/, 1953 to 12/16/55, 19 , that I last saw the deceased alive on 12/16, 1955, and that death occurred at 2:15 P m., from the causes and on the date stated above.

23. SIGNATURE George H. Taft, M.D. (Degree or title) C	23b. ADDRESS 2204 East 18th St.	23c. DATE SIGNED 12/19/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12/19/55	24c. NAME OF CEMETERY OR CREMATORY Maple Grove Cemetery	24d. LOCATION (City, town, or county) (State) Tonganoxie Kans
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DATE REC'D BY LOCAL REG. 12-27-55	REGISTRAR'S SIGNATURE Neva Marshall	25. FUNERAL DIRECTOR'S SIGNATURE Manlove & Williams ADDRESS 1729 Lydia
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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 *Raymond Wilcox*.....
Licensed Embalmer No. *468*.....

P. O. Address *H. C. 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.