

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35070**

FILED OCT 31 1956

BIRTH NO. _____ REG. DIST. NO. **291** PRIMARY REG. DIST. NO. **5997** Registrar's No. **72**

1. PLACE OF DEATH a. COUNTY Puixnam		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Shelburne	
b. CITY (If outside corporate limits, write RURAL and give township) Wilson		c. CITY (If outside corporate limits, write RURAL and give township) Milan Mo	
c. LENGTH OF STAY (in this place) 7 days		d. STREET ADDRESS (If rural, give location) 1251	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lemona Nursing Home			

3. NAME OF DECEASED (Type or Print) Amos P BAKER			4. DATE OF DEATH (Month) (Day) (Year) Oct 17 1956			
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov 8 - 1869		9. AGE (In years last birthday) Months Days 86 11 9	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Harris Mo		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Peter Baker	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE Catherine Baker
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Rachel Noel Stanbury		ADDRESS Stanbury
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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		INTERVAL BETWEEN ONSET AND DEATH 3 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerosis DUE TO (c) hypertension		years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senile debility			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 33ix	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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **April 1955**, to **Oct 17, 1956**, that I last saw the deceased alive on **Oct 17, 1956**, and that death occurred at **6 p. m.**, from the causes and on the date stated above.

23a. SIGNATURE Chas L Judd D.O.	(Degree or title)	23b. ADDRESS Amosville Mo 10-18-56	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Oct 19 1956	24c. NAME OF CEMETERY OR CREMATORY Brackett	24d. LOCATION (City, town, or county) (State) Country Mo
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DATE REC'D BY LOCAL REG. 10-29-56	REGISTRAR'S SIGNATURE Marvell Turbine	25. FUNERAL DIRECTOR'S SIGNATURE Judd & Daigne	ADDRESS Keutem
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WHILE FILING - 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
Student Embalmer

Signed T. Howard Judd

Licensed Embalmer No. 3240

P. O. Address New Town 7

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.