

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

37242  
STATE FILE NUMBER

FILED NOV 26 1956

Registration District No. 389 Primary Registration District No. 5161 Registrar's No. 16

Health, Welfare and Public Service  
300/5120  
-56  
All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Use only black ink or ribbon typewrite if possible.

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Callaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cedar TWP</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>New Bloomfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Ingram Nursing Home</u> Length of stay in lb <u>1 month</u>		d. STREET ADDRESS (If outside, give location) <u>7 mi. SE. New Bloomfield</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles Robert Baldwin</u> First Middle Last		4. DATE OF DEATH <u>Nov 14 56</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 2 1867</u>
9. AGE (In years last birthday) <u>89</u>		10. IF UNDER 1 YEAR OF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTH PLACE (City and state or country) <u>Callaway Co. MO</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Baldwin</u>	
14. MOTHER'S MAIDEN NAME <u>Ann Carr</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>NO</u>		17. INFORMANT <u>Dr. Josie Williams New Bloomfield</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Valvular Heart Disease</u> DUE TO (b) <u>arterio Sclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>Two year</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4214	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY. Hour a. m. p. m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>July 1-1954</u> to <u>Nov 14-56</u> and last saw her/him alive on <u>Nov 12-56</u> . Death occurred at <u>6:30 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>E. M. O. Risk M.D.</u> (Name or title)		22b. ADDRESS <u>New Bloomfield Mo</u>	
22c. DATE SIGNED <u>Nov 14-56</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>Nov-16-56</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Whittington Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Near New Bloomfield Mo</u>
24. FUNERAL DIRECTOR <u>Robert Clayton Jr. New Bloomfield</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>11-15-56</u>	25. REGISTRAR'S SIGNATURE <u>LeRoy Clayton</u>

(Licensed Embalmer's Statement on Reverse Side)

---

---

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.....  
Licensed Embalmer No. 4417

P. O. Address New Bloomf

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.