

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12380
STATE FILE NUMBER

FILED APR 29 1957

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 229

Health,
Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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>Cape Girardeau</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cape Girardeau</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cape Girardeau</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Jackson Mo</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Southeast Hospital</u>		Length of stay in lb <u>4 days</u>	d. STREET ADDRESS (If outside, give location) <u>Greenway Rd</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>MAMIE BAKER GRAVES</u>			4. DATE OF DEATH Month Day Year <u>April 14, 1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 4, 1885</u>	9. AGE (In years (last birthday)) <u>72</u> IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and state or country) <u>Marble Hill Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Amaziah Baker</u>			14. MOTHER'S MAIDEN NAME <u>Emma Walker</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>J.B. Grove, Jackson Mo.</u>		
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>Diabetes Mellitus</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)					DUE TO (c)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					<u>260X</u>
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 Month, Day, Year a. m. p. m.					
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>4-5-57</u> to <u>4-14-57</u> and last saw her alive on <u>4-13-57</u> Death occurred at <u>Southeast Hospital</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>E.F. McDonald, M.D.</u> (Degree or title)			22b. ADDRESS <u>Jackson, Mo.</u>		22c. DATE SIGNED <u>4-20-57</u>
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify)	23b. DATE <u>April 16, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Russell Heights</u>		23d. LOCATION (City, town, or county) (State) <u>Jackson Mo.</u>	
24. FUNERAL DIRECTOR <u>A. Miller</u> ADDRESS <u>Jackson Mo</u>		25. DATE RECD. BY LOCAL REG. <u>4-22-1957</u>		26. REGISTRAR'S SIGNATURE <u>G. C. Summers</u>	

(Licensed Embalmer's Statement on Reverse Side)

44-0

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 *John O. Conroy*

Licensed Embalmer No. *432*

P. O. Address *Jackson, Miss.*

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.