

FILED MAY 24 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18419

STATE FILE NUMBER

4327

 Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <input checked="" type="checkbox"/>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis, Missouri</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>25 ST. LOUIS CITY HOSP. #1</u>		Length of stay in life <u>Life</u>	d. STREET ADDRESS (If outside, give location) <u>1235 South 7th.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>E.</u> Last <u>BAKER</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>4</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-19-1884</u>	9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handy man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</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>Yes</u>	17. INFORMANT Address <u>Flora Hagedorn, 6524 Hoffman</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>Myocardial Infarct</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <u>420-1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchitis Bronchiectasis emphysema</u>					INTERVAL BETWEEN ONSET AND DEATH <u>10 "</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 _____ 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>4/29/57</u> to <u>5/4/57</u> and last saw her/him alive on <u>5/4/57</u> . Death occurred at <u>6:00 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Ray A. Thub MD.</u>			22b. ADDRESS <u>1515 LAFAYETTE</u>		22c. DATE SIGNED <u>5-6-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>5-8-1957</u>	23c. NAME OF CEMETERY OR INTERMENT PLACE <u>St. Trinity Lutheran</u>	23d. LOCATION (City, town, or county) <u>St. Louis-County, Mo.</u>		(State) _____
24. FUNERAL DIRECTOR ADDRESS <u>McLAUGHLIN'S, 2301 Lafayette</u>		25. DATE RECD. BY LOCAL REG. <u>MAY 6 '57</u>	26. REGISTRAR'S SIGNATURE <u>Charles Smith MD</u>		

(Licensed Embalmer's Statement on Reverse Side)

Health,
Welfare
Public
Service300
1-56

All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *James P. Chapman*
Licensed Embalmer No. *5*

P. O. Address *St. Louis*

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.