

Health,
Welfare
Public
Service

300
-57

FILED AUG 12 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24393
STATE FILE NUMBER 3427
Registrar's No.

Registration District No. 149 Primary Registration District No. 1002

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Johnson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Prairie Village ⁴⁵⁰	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Elms Nursing Home		d. STREET ADDRESS 2704 West 71st Street	
3. NAME OF DECEASED (Type or print) First Paul Middle S. Last Baker		4. DATE OF DEATH Month 7 Day 21 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-10-1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Public Fox Acct.		11. BIRTHPLACE (City and state or country) Randolph County, Missouri	
13a. FATHER'S NAME Luther Baker		14. NAME OF HUSBAND OR WIFE Florence Munger Baker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		17. INFORMANT Address Florence Baker 2704 W. 71st St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Viral Pneumonitis		INTERVAL BETWEEN ONSET AND DEATH 1 day	
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. } DUE TO (b) Spastic Hemiparesis		24 mos	
DUE TO (c) Cervical Cord Tumor - Operated		24 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the immediate cause in PART I (a) Undernutrition - 1 year		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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 g.m. p.m.			
20d. INJURY OCCURRED WHILE AT <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 1-2-18-44 to 7-21-57 and last saw him alive on 7-21-57 Death occurred at 5 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Graham Asher M.D.		22b. ADDRESS 1270 Professional Bldg. Kansas City 6, Mo.	
22c. DATE SIGNED 7-22-57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-23-1957	
23c. NAME OF CEMETERY OR CREMATORY Forest Hill		23d. LOCATION (City, town, or county) (State) Kansas City, Missouri.	
24. FUNERAL DIRECTOR Stine & McClure		25. DATE RECD. BY LOCAL REG. 7-22-57	
ADDRESS K. C. Mo.		26. REGISTRAR'S SIGNATURE Neva Minshall	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
Graham Asher

All diseases in Part I must be causally related.

Dr. Deakam Cooper
122 Prof Building
W. R. 8188
2003

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 *William M. Zurne*

Licensed Embalmer No. *4648*

P. O. Address *Kansas City*
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.