

pt. Health,
, & Welfare
S. Public
lth Service

S. 300
ev. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
W.R. Peters on

FILED NOV 14 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35651

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4720

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION General #2		Length of stay in lb 70 days 4 weeks	d. STREET ADDRESS (If outside, give location) 635 Troost		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Tishia Middle Baker Last Baker			4. DATE OF DEATH Month October Day 10 Year 1957		
5. SEX 3 Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/1/1901	9. AGE (In years last birthday) 56	IF UNDER 1 YEAR Months 1 Days 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME John Walls		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Johnnie Baker Sr		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Address Johnnie B. Baker, son 1944 N. 5th- KCK		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arrhenoblastoma of ovary with abdominal metastasis.					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____					21.7
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). 175X					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 _____ a.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 9-5-57 to 10-10-57 and last saw her alive on 10-10-57 Death occurred at 1:30 P m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE M.R. Peterson MD (Degree or title) 0			22b. ADDRESS 600 East 22nd Street		22c. DATE SIGNED 10-14-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10/16/57	23c. NAME OF CEMETERY OR CREMATORY Westlawn		23d. LOCATION (City, town, or county) (State) K.C. Wyandotte Kansas	
24. FUNERAL DIRECTOR ADDRESS Bailey Funeral Home K.C. Kansas			25. DATE RECD. BY LOCAL REG. 10-16-57	26. REGISTRAR'S SIGNATURE Hera Marshall	



STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
X by me, or by, Student Embalmer No.
working under my personal supervision.

Student

Signature of Student Embalmer

VE-01-01

VE-01-01

Signed

C. Kenneth Herford

VE-01-01 Licensed Embalmer No. 24497

P. O. Address *F. C. ...*

VE-01-01 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.