

FILED MAR 27 1958

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3239

1. PLACE OF DEATH
a. COUNTY _____ 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY Scotland

b. CITY (If outside corporate limits, write RURAL and give township) OR St. Louis, Missouri c. LENGTH OF STAY (in this place) 2 days
c. CITY OR TOWN Memphis, 0999 d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Children's Hospital e. STREET ADDRESS (If rural, give location) R. R. #2

3. NAME OF DECEASED (Type or Print) a. (First) Paul b. (Middle) Lynn c. (Last) Baker 4. DATE OF DEATH (Month) (Day) (Year) 3-19-58

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, ~~WIDOWED~~, ~~SEPARATED~~, ~~DIVORCED~~ Never Married 8. DATE OF BIRTH 2-26-58 9. AGE (in years last birthday) 21 IF UNDER 1 YEAR Months 18 Days 18 IF UNDER 24 HRS. Hours 18 Min. 18

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (City and State or Foreign Country) Kirkville, Missouri 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Ray T. Baker 13b. MOTHER'S MAIDEN NAME Nellie Robinson 14. NAME OF HUSBAND OR WIFE Single

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. None 17. INFORMANT'S SIGNATURE OR NAME Alice Trowbridge ADDRESS 500 S. Kingshighway

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) congestive cardiac failure
ANTECEDENT CAUSES DUE TO (b) Cyanotic congenital heart disease
DUE TO (c) 754.5
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 3-17-, 1958, to 3-19-, 1958, that I last saw the deceased alive on 3-19-, 1958, and that death occurred at 2:40 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Barbara Jones, M.D. 23b. ADDRESS 500 S. Kingshighway 23c. DATE SIGNED 3-19-58

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE 3-19-58 24c. NAME OF CEMETERY OR CREMATORY _____ 24d. LOCATION (City, town, or county) (State) Memphis, Mo.

DATE REC'D BY LOCAL REG. MAR 19 1958 REGISTRAR'S SIGNATURE Paul Smith 25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe ADDRESS 4700 Washington Blvd.

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *Robert M. Murray*
Licensed Embalmer No. *37498*

P. O. Address *St. Louis, 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.