

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-036250
STATE FILE NUMBER
4750
Registrar's No.

FILED OCT 29 1958 Registration District No. 149 Primary Registration District No. 1002

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kansas</u> COUNTY <u>Wynantia</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Wynantia City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Wynantia City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF DECEASED (NOT in hospital, give location) <u>Mary Agnes Baker</u>		Length of stay in lb HOSPITAL OR INSTITUTION <u>None</u>	815 th STREET ADDRESS <u>1153 Springfield</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>AGNES</u> Last <u>BAKER</u>			4. DATE OF DEATH Month <u>10</u> Day <u>7</u> Year <u>1958</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-17-1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE (In years last birthday) <u>65</u> IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
11. BIRTHPLACE (City and state or country) <u>Moberly, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Henry Wilson</u>		13b. MOTHER'S MAIDEN NAME <u>unknown</u>	
14. NAME OF HUSBAND OR WIFE <u>Sheldon Baker</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 <u>Sheldon Baker</u> Address <u>K.C. Mo. 1153 Springfield</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>arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4312</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u> <u>6 years</u>
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. 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>7-1-58</u> to <u>10-7-58</u> and last saw her alive on <u>10-7-58</u> Death occurred at <u>5:45 pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Frank Paul Laurentz</u> (Degree or title)		22b. ADDRESS <u>428 S. White Ave</u>	
22c. DATE SIGNED <u>10-7-58</u>		23a. BURIAL, CREMATION, REMOVAL (Specify)	
23b. DATE <u>10-8-1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Hope Cem.</u>	
23d. LOCATION (City, town, or country). (State) <u>Kansas City, Kans.</u>		24. FUNERAL DIRECTOR <u>Daniel Brax</u> ADDRESS <u>KC Kans.</u>	
25. DATE RECD. BY LOCAL REG. <u>10-9-58</u>		26. REGISTRAR'S SIGNATURE <u>Neve Minshall</u>	

ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
Frank Paul Laurentz

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.

Dr. Kussingana.
Dial 10-7-1459 545pm
Pearls Nursing Home



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 *Leonard Lassantivo*

Licensed Embalmer No. *4554*
P. O. Address *KC 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.