

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-016028

FILED VS. MAY 3 1960 179

Primary Registration District No. 5667 Registrar's No. 66

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Lincoln		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY MONTGOMERY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bedford Twp.		c. CITY OR TOWN High Hill	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Lincoln Co. Memorial Hospital		d. STREET ADDRESS (If outside, give location) High Hill	

3. NAME OF DECEASED (Type or print) First LUTISHE Middle ANN Last BAKER			4. DATE OF DEATH Month APRIL Day 27 Year 1960			
5. SEX F	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-22-72	9. AGE (last birthday) 88	IF UNDER 1 YEAR Months Days Hours Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Big Springs Mo	12. CITIZEN OF WHAT COUNTRY
13a. FATHER'S NAME Charles P. Pion	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Leo Baker	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. ---	17. INFORMANT Hughly Baker New Haven Mo	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Medullary Failure		INTERVAL BETWEEN ONSET AND DEATH 24 hours
DUE TO (b) Cerebral thrombosis		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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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 5:25 a.m. P. Month 4 Day 27 Year 1960			

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 High Hill Mo	COUNTY Montgomery	STATE Mo
21. I attended the deceased from 4-27-60 to 4-27-60 and last saw her alive on 4-27-60 Death occurred at 5:25 P. on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE R. Blackwell P.O.	(Degree or title)	22b. ADDRESS Troy Mo	22c. DATE SIGNED 4-27-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-30-60	23c. NAME OF CEMETERY OR CREMATORY Oak Grove	23d. LOCATION (City, town, or county) (State) Jonesburg Mo
24. FUNERAL DIRECTOR G. A. Harding	ADDRESS Jonesburg Mo	25. DATE RECD. BY LOCAL DES. 4-27-1960	26. REGISTRAR'S SIGNATURE Charlotte Leek

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

for by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Carl A. Harding

Licensed Embalmer No. 4118

P. O. Address Jonesburg

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.