

VITAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-016071

FILED VS APR 19 1960

STATE FILE NUMBER

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 71

1. PLACE OF DEATH a. COUNTY <u>Livingston</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u> Length of stay in lb <u>12 hrs.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>City Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Livingston</u> c. CITY OR TOWN <u>Chillicothe</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>100 St. Paul St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>RANDY</u> Middle <u>DEAN</u> Last <u>BAKER</u>			4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/29/1958</u>	9. AGE (last birthday) <u>16</u> Months Days Hours Min.	IF UNDER 1 YEAR IF UNDER 24 HR		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (City and state or country) <u>Chillicothe, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Milford Baker</u>			13b. MOTHER'S MAIDEN NAME <u>Alma Stephens Cobb</u>		14. NAME OF HUSBAND OR WIFE <u>Infant</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 Address <u>Milford Baker; Chillicothe, Mo.</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>2° Burns of face neck-shoulders arms hands + legs</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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 type="checkbox"/> No <input type="checkbox"/> Unknown						INTERVAL BETWEEN ONSET AND DEATH <u>17 hours.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input checked="" 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.) <u>Pulled hot grease from stove</u>			
20c. TIME OF INJURY Hour <u>4:30</u> p.m. Month, Day, Year <u>4 9 60</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>his home.</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>Chillicothe Livingston Mo</u>	
21. I attended the deceased from <u>4-8-60</u> to <u>4-9-60</u> and last saw him alive on <u>4-9-60</u> Death occurred at <u>9:30</u> A.M. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Joseph F. Yale M.D.</u>				22b. ADDRESS <u>Chillicothe Mo</u>		22c. DATE SIGNED <u>4-11-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4/11/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Resthaven Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Chillicothe, Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS <u>NORMAN FUNERAL HOME: Chillicothe, Mo. 4/13/60</u>				25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE <u>Frances B Neill</u>	

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
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed  _____

Licensed Embalmer No. 4036

P. O. Address Chillicothe,

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.