

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-022033

FILED VS MAY 25 1960

Registration District No. 391 Primary Registration District No. 4504 Registrar's No. 10

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>STODDARD</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ADVANCE</u> Length of stay in lb <u>14 years</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 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> b. COUNTY <u>STODDARD</u> c. CITY OR TOWN <u>ADVANCE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
---	--	--	--

3. NAME OF DECEASED (Type or print) First Middle Last <u>RAYMOND M. BAKER</u>			4. DATE OF DEATH Month Day Year <u>APRIL 10 1960</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</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>11-21-1889</u>	9. AGE (last birthday) <u>70</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>20</u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (City and state or country) <u>BLOOMFIELD, INDIANA</u>	
12a. FATHER'S NAME <u>ROBERT BAKER</u>		12b. MOTHER'S MAIDEN NAME <u>ELIZABETH FOULK</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go on or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>381 146911</u>		
17. INFORMANT <u>MINNIE BAKER</u>			14. NAME OF HUSBAND OR WIFE <u>MINNIE BAKER</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>Medullary failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Circulatory failure</u> DUE TO (c) <u>metastatic Carcinoma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 HOURS</u> <u>3 DAYS</u> <u>6 M O.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pneumonia</u>		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

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 NOV 10-59 to 4-10-60 and last saw him alive on 4-10-60
 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 (Degree or title) <u>D. A. Masters D.O.</u>	22b. ADDRESS <u>Advance, Mo.</u>	22c. DATE SIGNED <u>4-11-60.</u>
---	-------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-13-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Morgan</u>	23d. LOCATION (City, town, or county) (State) <u>Advance Mo.</u>
--	-----------------------------	---	---

24. FUNERAL DIRECTOR ADDRESS <u>W. H. Morgan Advance, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>4/11/60</u>	26. REGISTRAR'S SIGNATURE <u>Bernice Moore</u>
--	--	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

MAY 27 1960

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 W^m H. Morgan

Licensed Embalmer No. 464

P. O. Address Advance,

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.