

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 5 1960 042

=60-022348
STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 1000 Registrar's No. 701

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph, Missouri		Length of stay in 1b 1 Mo.	c. CITY OR TOWN St. Joseph, Missouri Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Arnold Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2231 North 2nd Street Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last SARAH NEVADA BAKER			4. DATE OF DEATH Month Day Year June 23 1960			
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH May 4, 1870	9. AGE (last birthday) 90	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Household Executive		10b. KIND OF BUSINESS OR INDUSTRY Household Executive		11. BIRTHPLACE (City and state or country) Earl Town, Kansas		12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Eugene Lasley		13b. MOTHER'S MAIDEN NAME Lydia Hamm		14. NAME OF HUSBAND OR WIFE George G. Baker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unk		17. INFORMANT Address Mr. Gene Baker, 1904 Delmar	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident			INTERVAL BETWEEN ONSET AND DEATH Yes.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Old Arteriosclerosis Gen			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Old Fract Hip - not healed.			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.	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 **2-18-60** to **6-23-60** and last saw her alive on **6-23-60**
Death occurred at **11:30 P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Signed or title) Robert W. Kieber, M.D.	22b. ADDRESS St. Joseph, Mo	22c. DATE SIGNED 6-24-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 27, 1960	23c. NAME OF CEMETERY OR CREMATORY Mount Auburn Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri
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24. FUNERAL DIRECTOR ADDRESS Hester Bowman St. Joseph, Missouri	25. DATE RECD. BY LOCAL REG. June 27, 1960	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell
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DOCUMENT

BY AFFIDAVIT OF R.W. Kieber, M.D. MEDICAL CERTIFICATION

OCT 9 1 1960

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 William Spalding

Licensed Embalmer No. 4535

P. O. Address St Joseph

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.