

FEDERAL BUREAU OF INVESTIGATION
 FBI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-026707

FILED 16 AUG 8 1960 149

Primary Registration District No. 1002 Registrar's No. 3812

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 2 weeks		c. CITY OR TOWN Independence		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Research Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 626 N. Delaware		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First WILLIAM Middle FRANCIS Last BAKER				4. DATE OF DEATH Month July Day 23 Year 1960									
5. SEX Male		6. COLOR OR RACE White		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 5/23/95		9. AGE (last birthday) 65		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired RR Station Agent				10b. KIND OF BUSINESS OR INDUSTRY GM&O Railroad		11. BIRTHPLACE (City and state or country) Austin, Missouri		12. CITIZEN OF WHAT COUNTRY USA					
13a. FATHER'S NAME William Francis Baker				13b. MOTHER'S MAIDEN NAME Katherine Jane Cobb				14. NAME OF HUSBAND OR WIFE Lillian L. 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. 709-12-0530		17. INFORMANT Mrs. Lillian L. Baker		Address 626 N. Delaware Indep., Mo.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis - Right Ventral artery DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) Generalized Arterio Sclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes Mellitus 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 2 weeks			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 July 8, 1960 to July 23, 1960 Death occurred at 9:50 AM on the date stated above, and to the best of my knowledge, from the causes stated.										Last saw him alive on July 23, 1960			
22a. SIGNATURE Carl R. Ferris M.D.				22b. ADDRESS 53 S. 5th St Bldg Kansas City Mo				22c. DATE SIGNED 7-25-60					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/25/60		23c. NAME OF CEMETERY OR CREMATORY Odessa Cemetery		23d. LOCATION (City, town, or county) Odessa, Missouri		(State)					
24. FUNERAL DIRECTOR Geo. C. Carson & Sons				ADDRESS Indep., Mo.		25. DATE RECD. BY LOCAL REG. 7-25-60		26. REGISTRAR'S SIGNATURE Irene Marshall					

DOCUMENT

BY AFFIDAVIT OF
 Carl R. Ferris
 MEDICAL CERTIFICATION

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 Dean W. Huff

Licensed Embalmer No. 4914
P. O. Address Indy, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.