

Dept. Health,
nc., & Wellfa
l. S. Public
Health Service

V. S. 300
Rev. 1-57

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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.
Reporting the medical certificate in this specific manner required by 193.1240 MoRS 1949.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| 7-60-045442 | | STATE FILE NUMBER | |
|---|--------------------------------------|--|--|
| FILED VS DEC 2 9 1960 Registration District No. <u>71</u> Primary Registration District No. <u>3012</u> Registrar's No. <u>114</u> | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Clay</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>Lawson</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR Veterans Administration <u>tion Hospital</u> Length of stay in lb <u>1</u> | | d. STREET ADDRESS (If outside, give location) <u>Route-2</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>LARRY</u> Middle <u>W.</u> Last <u>BAXTER</u> | | | 4. DATE OF DEATH Month <u>11</u> Day <u>15</u> Year <u>60</u> |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 2-WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-4-92</u> |
| 9. AGE (In years last birthday) <u>68</u> | | IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> | IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</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>Farm</u> | 11. BIRTHPLACE (City and state or country) <u>Vibbard, Mo.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13a. FATHER'S NAME <u>John C. Baxter</u> | | 13b. MOTHER'S MAIDEN NAME <u>Kate Goodwin</u> | 14. NAME OF HUSBAND OR WIFE <u>- - - -</u> |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWI</u> | | 16. SOCIAL SECURITY NO. | 17. INFORMANT <u>Larry W. Baxter, Jr., son, Lawson, Mo.</u> Address |
| 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>Bronchopneumonia, left</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>Approx 5 days</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ | | | <u>491XA</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>1. Tuberculosis, pulmonary, far advanced, inactive (2) Duodenal ulcers, active (3) Chronic Cor. Pulmonale</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 _____ Month, Day, Year _____ a.m. _____ p.m. | | | |
| 20d. INJURY OCCURRED WHILE AT NOT WHILE WORK <input type="checkbox"/> 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. Attended the deceased from <u>November 14, 1960</u> <u>November 15, 1960</u> <u>on the date stated above; and to the best of my knowledge, from the causes stated.</u> | | | |
| 22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D. Pathologist</u> | | 22b. ADDRESS <u>VACC, Ex. Spgs Division</u> <u>Excelsior Springs, Mo.</u> | 22c. DATE SIGNED <u>11-16-60</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>11-17-1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u> | 23d. LOCATION (City, town, or county) (State) <u>Liberty, Missouri</u> |
| 24. DIRECTOR <u>Richard Funeral Home, Inc.</u> ADDRESS <u>Excelsior Springs, Missouri</u> | | 25. DATE RECD. BY LOCAL REG. <u>12/2/60</u> | 26. REGISTRAR'S SIGNATURE <u>[Signature]</u> |

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ~~or by~~, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Ralph C. Van Landingham*

Licensed Embalmer No. *4009*
P. O. Address *Delmar Springs, Mo.*

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.