

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035741

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 082 Primary Registration District No. 5010 Registrar's No. 29

AMENDED

FILED NOV 6 1961

1. PLACE OF DEATH a. COUNTY <u>Andrew</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Nodaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bolckow</u>		Length of stay in lb <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Barnard</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2 mi S. Co. line</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u></u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Daniel</u> Last <u>Baker</u>			4. DATE OF DEATH Month <u>10</u> Day <u>22</u> Year <u>1961</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>Cau.</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>3-16-1943</u>	9. AGE (last birthday) <u>18</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (City and state or country) <u>Barnard, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Fred Baker</u>		13b. MOTHER'S MAIDEN NAME <u>Ruby Mae Ridlon</u>	
14. NAME OF HUSBAND OR WIFE <u>none</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Fred Baker - Bolckow, Mo</u>		Address <u></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>Cerebral Concussion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
DUE TO (b) <u>Blow to head</u>		
DUE TO (c) <u>Automobile accident</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Basilar skull fracture</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 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>Was southbound, driving automobile, on the</u>
20c. TIME OF INJURY Hour <u>2:00</u> a.m. <u></u> Month, Day, Year <u>Oct. 23, 1961</u>	shoulder of northbound lane, hit northbound car head-on.	
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>U.S. Highway 71</u>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>R.F.D. Bolckow Andrew Mo.</u>
21. I attended the deceased from <u>2:00</u> to <u></u> and last saw him alive on <u></u> . Death occurred at <u>2:00</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>W.S. Maxwell, D.O., Former</u>	22b. ADDRESS <u>307 W. Main, Savannah, Mo.</u>	22c. DATE SIGNED <u>10/25/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-24-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Masonic Cem.</u>
23d. LOCATION (City, town, or county) <u>Barnard, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>10-30-61</u>	26. REGISTRAR'S SIGNATURE <u>Killian Sparks</u>
24. FUNERAL DIRECTOR <u>Alchison - Maryville, Mo.</u>	Address <u></u>	<u>Rung</u>

DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
SHOULD READ  
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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *G M Altkar*

Licensed Embalmer No. 3279

P. O. Address Maryville

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.