

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041585

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 175 Primary Registration District No. 3036 Registrar's No. 6

FILED NOV 16 1961

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Aurora</u> Length of stay in 1b _____ c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Aurora Comm. Hospital</u> 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>Lawrence</u> c. CITY OR TOWN <u>Aurora</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS <u>At. - 1</u> (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First <u>Maxine</u> Middle <u>(mimi)</u> Last <u>Baker</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>9</u> Year <u>1961</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau.</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>6/14/1916</u>	9. AGE (last birthday) <u>45</u>	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) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Marianville, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Herman Hendrickson</u>		13b. MOTHER'S MAIDEN NAME <u>Mabel Rogers</u>		14. NAME OF HUSBAND OR WIFE <u>Johnny Baker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Johnny Baker; Aurora, 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>Terminal uremia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <input type="checkbox"/> DUE TO (b) <u>Hypostatic pneumonia</u> <input type="checkbox"/> DUE TO (c) <u>Congenital Polycystic Kidneys, bilateral</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>16 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) _____		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 <u>8:40</u> on <u>11-9-61</u> and last saw her <u>11-9-61</u> alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE <u>A. P. Caputo</u> (Degree or title) <u>M.D.</u>	22b. ADDRESS <u>Rue, Mo.</u>	22c. DATE SIGNED <u>11-9-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11/11/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maple Park</u>	23d. LOCATION (City, town, or county) (State) <u>Aurora, Mo</u>

24. FUNERAL DIRECTOR <u>Arnold Funeral Home, Aurora, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>Nov. 9, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Georgell Langley</u>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

Nov. 10, 1961

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 James W. Crafton

Licensed Embalmer No. 4660

P. O. Address Alvord, O.

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.