

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-001406

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 142

Primary Registration District No. 5556

Registrar's No. 5

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

1. <b>FILED</b> JAN 29 1962		2. <b>USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Howell</u>		a. STATE <u>Mo.</u> b. COUNTY <u>Shannon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Goldsberry</u>		c. CITY OR TOWN <u>Winona, : Rural</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>Rural Route 1</u>	
3. <b>NAME OF DECEASED</b> (Type or print) First <u>Julian</u> Middle <u>Mortimer</u> Last <u>Baker</u>		4. <b>DATE OF DEATH</b> Month <u>January</u> Day <u>9</u> Year <u>1962</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</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>1/26/10</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assembler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Equality, Ill.</u>	
11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Dennis A. Baker</u>		13b. MOTHER'S MAIDEN NAME <u>Nellie Lacey</u>	
14. NAME OF HUSBAND OR WIFE <u>Beulah L. Baker</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>W.W.</u> <u># 2</u>	
16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT <u>Beulah Baker Rt. 1 Winona, Mo.</u>	
18. <b>CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO (b) <u>Malignant tumor of brain</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 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>1959</u> to <u>Jan 1962</u> and last saw her <u>Jan. 9, 1962</u> Death occurred at <u>Jan 9, 1962</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>M.C. Walton M.D.</u>		22b. ADDRESS <u>At View, Mo.</u>	
22c. DATE SIGNED _____		22d. LOCATION (City, town, or county) (State) <u>Fremont, Missouri</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1/11/1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Site</u>	
23d. FUNERAL DIRECTOR <u>Duncan Funeral Home Mtn. View, Mo.</u>		23e. DATE RECD. BY LOCAL REG. <u>1-22-62</u>	
23f. REGISTRAR'S SIGNATURE <u>Laura Mitchell</u>		23g. _____	

(Licensed Embalmer's Statement on Reverse Side)

VS JAN 30 1962

MAR 2 1962

VS FEB 1 1962

FEB 27 1962

**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 Charles D. Cartain

Licensed Embalmer No. 5107

P. O. Address Mt. View, N.J.

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.