

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-001483

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 200

STATE FILE NUMBER

AMENDED

FILED JAN 25 1962

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| 1. PLACE OF DEATH a. COUNTY <u>JACKSON</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>HARRISON</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> | | c. CITY OR TOWN <u>BETHANY</u> | |
| Length of stay in 1b <u>3 wks</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LUKE'S HOSPITAL</u> | | d. STREET ADDRESS (If outside, give location) <u>1340 MILLER ST.</u> | |
| Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|---|----------------------------------|---|---|---|---|
| 3. NAME OF DECEASED (Type or print) First <u>Coy</u> Middle <u>E.</u> Last <u>BAKER</u> | | | 4. DATE OF DEATH Month <u>1-</u> Day <u>11-</u> Year <u>1962</u> | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</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>2-17-1883</u> | 9. AGE (last birthday) <u>78</u> | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>HARRISON Co. Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>WESLEY BAKER</u> | | 13b. MOTHER'S MAIDEN NAME <u>SARAH A. GLAZE</u> | | 14. NAME OF HUSBAND OR WIFE <u>CATHERINE 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>CATHERINE BAKER BETHANY, Mo.</u> | |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Pneumonia</u> | | |
| DUE TO (b) <u>Interstitial Nephropathy</u> | | |
| DUE TO (c) <u>Acute Myelogenous Leukemia</u> | | |
| 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 |

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| 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 checked="" 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 12-30-61 to 1-11-62 and last saw him alive on 1-11-62
Death occurred at 1:25 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <u>Robert K. Skillman M.D.</u> | | 22b. ADDRESS <u>4635 Wyonette, K.C. Mo.</u> | | 22c. DATE SIGNED <u>1-13-62</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> | 23b. DATE <u>1-13-1962</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>GLAZE CEMETERY CAINSVILLE, Mo.</u> | | 23d. LOCATION (City, town, or county) (State) |
| 24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS N.K.C., Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>1-13-62</u> | 26. REGISTRAR'S SIGNATURE <u>Ruth Long</u> | |

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 Robert K. Skillman
 SHOULD READ
 ITEM NO.

DR. BYERL OR SKILLMAN
4320 WORNALL RD.

JAN 26 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 John W. Hale
Licensed Embalmer No. 4949

P. O. Address St. Louis, 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.