

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED SEP 24 1962

-62-034219
 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB
 AMENDED

Registration District No. 93 Primary Registration District No. 4153 Registrar's No. _____

VS 300
 Rev. 4/59

1 0290
 2 0290
 3 1
 4 0
 5 3
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 7 1
 8 2
 9 332X
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 12 1-2
 13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON
 Hugh Baker, D.O.

1. PLACE OF DEATH a. COUNTY <u>Dade</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Dade</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lockwood Mo</u>		Length of stay in lb <u>3wks</u>	c. CITY OR TOWN <u>Greenfield Mo</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Memorial Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2 mi N.W</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Washington</u> Last <u>Dickerson</u>			4. DATE OF DEATH Month <u>Sept</u> Day <u>8</u> Year <u>1962</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>April 22 1880</u>
9. AGE (last birthday) <u>82</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>16</u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
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>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Ky</u>
12. CITIZEN OF WHAT COUNTRY <u>usa</u>		13a. FATHER'S NAME <u>George W Dickerson</u>	
13b. MOTHER'S MAIDEN NAME <u>Mary Estham</u>		14. NAME OF HUSBAND OR WIFE	
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> </u>	
17. INFORMANT Address <u>Edna Eastburn Otisville Michigan</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a) <u>medullary fever</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 h.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>cerebral thrombosis</u>		<u>30 days</u>	
DUE TO (c) <u>arteriosclerosis</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	
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 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 <u> </u> a.m. <u> </u> 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>8-15-62</u> to <u>9-8-62</u> and last saw him alive on <u>9-7-62</u> Death occurred at <u>12:10 A</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Hugh Baker D.O.</u>		22b. ADDRESS <u>Miller, Mo.</u>	22c. DATE SIGNED <u>9-11-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept. 10 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bona</u>	23d. LOCATION (City, town, or county) (State) <u>Dade Mo.</u>
24. FUNERAL DIRECTOR <u>Allison Funeral Home Greenfield Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>9/15/1962</u>	26. REGISTRAR'S SIGNATURE <u>J. C. Canada</u>

SEP 25 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 W.R. Allison

Licensed Embalmer No. 4404

P. O. Address Greenfield 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.