

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-039790
STATE FILE NUMBER

Registration District No. 294 Primary Registration District No. 3056 Registrar's No. 245

FILED OCT 18 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY Randolph		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Macon	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Moberly		Length of stay in 1b	c. CITY OR TOWN Callao
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Whitaker Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 205 S. Fifth
3. NAME OF DECEASED (Type or print) GROVER B. BAKER		First Middle Last	4. DATE OF DEATH Month Day Year Oct. 1 1962
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/28/1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Rural Mail Carrier	9. AGE (last birthday) 78
13a. FATHER'S NAME John W. Baker		13b. MOTHER'S MAIDEN NAME Mary Jane Claybrook	11. BIRTHPLACE (City and state or country) Macon Co., Mo.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	12. CITIZEN OF WHAT COUNTRY U.S.A.
17. INFORMANT Verne W. Baker		14. NAME OF HUSBAND OR WIFE Florence Leist Baker	
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) Acute Circulatory Failure			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Myocardial Infarction			
DUE TO (c) Arteriosclerosis			
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 Month, Day, Year a.m. p.m.		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 <u>2/5/61</u> to <u>10/1/62</u> and last saw her alive on <u>10/1/62</u> Death occurred at <u>6:05</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>E.T. Whitaker D.D.</i>		22b. ADDRESS 205 S. Fifth Moberly, Mo.	22c. DATE SIGNED 10/4/62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/4/1962	23c. NAME OF CEMETERY OR CREMATORY Locust Grove	23d. LOCATION (City, town, or county) (State) Callao Mo.
24. FUNERAL DIRECTOR ADDRESS Edwards Funeral Home Bevier, Mo.		25. DATE RECD. BY LOCAL REG. 10-4-62	26. REGISTRAR'S SIGNATURE <i>Leah S. Love</i>

DEC 13 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 *J. H. Edwards*

Licensed Embalmer No. 1961

P. O. Address *Berlin Md*

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.