

FILED AUG 12 1942

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

23691

Do not use this space.

1. PLACE OF DEATH

(a) County Adair Registration District No. 1
 (b) Township Primary Registration District No. Registered No. 207
 (c) City Keokuk or (d) Street No. 402 N. Franklin St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Minerva Baxter
 (a) Residence, No. 402 N. Franklin St. Keokuk Mo.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 29 1887

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
53 5 26

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Sales lady
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Scotland O. Mo.

FATHER 13. NAME David Baxter

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown ?

MOTHER 15. MAIDEN NAME Sarah Baxter

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown ?

17. INFORMANT (ADDRESS) Emergy Baxter
Keokuk Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Pleasant Hill DATE July 27 1942

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Loyle Moore
Keokuk Mo.

20. FILED 7/28/42 19 Mrs. J. P. Wagner
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 25 1942

22. I HEREBY CERTIFY That I attended deceased from May 9 1942 to July 25 1942

I last saw her alive on July 25 1942. Death is said to have occurred on the date stated above, at 12:30 P.M.
 The principal cause of death and related causes of importance were as follows:

metastatic carcinoma Date of onset

Other contributory causes of importance:

Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy? No.

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury 19.....
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased? ?
 If so, specify

(Signed) Rollin C. Jordan Jr. Mo.
 (Address) Keokuk, Missouri

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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JUL 10 1944

AUG 13 1962

RECEIVED

District Health Officer No. 10

District File Number 8-42-154 2

Date Filed AUG 11 1942

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 me

....., Registered Apprentice No.
working under my personal supervision.

Signed Lloyd Moore

Licensed Embalmer No. 3151

P. O. Address Doubling 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 this body is not embalmed, above space should be left blank.

STANDARD CERTIFICATE OF DEATH

State File No. 23691
Registrar's No. 207

Registration District No. 1 Primary Registration District No. 1

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Barksdale
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Minerva Baxter

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan 29 1888
(Month) (Day) (Year)

8. AGE: Years 55 Months 5 Days 10 min. If less than one day _____

9. Birthplace _____ (City, town, or county) (State or foreign country) MO

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 15 year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I first saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Melanotic carcinoma of ovaries Duration _____

Due to _____

Due to _____ H9a

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTAL

[The page contains extremely faint and illegible text, likely due to low contrast or poor scan quality. The text is arranged in several paragraphs across the page, but no specific words or phrases can be discerned.]