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

Do not use this space.

13.5465

File No. ..... Registered No. 127

1. PLACE OF DEATH
County: Jackson — Registration District No. .....
Township: Kansas — Primary Registration District No. .....
City: Kansas City (No. 807 Lydia St. ..... Ward)

2. FULL NAME: Emma Baker

(a) Residence. No. 807 Lydia St., ... Ward. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: Wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): June 26, 1855

7. AGE: Years 73 | Months | Days 20 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (CITY OR TOWN): Independence
(STATE OR COUNTRY): Mo

PARENTS
10. NAME OF FATHER: Jim Fann
11. BIRTHPLACE OF FATHER (CITY OR TOWN):
(STATE OR COUNTRY): Mo
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN):
(STATE OR COUNTRY): Unknown

14. INFORMANT: Eddie Baker
(Address): 1301 Troost

15. FILED 2-18, 1928 M M Crowe Registrar

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 2/16 19 28

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19..... that I last saw h..... alive on ..... 19..., and that death occurred, on the date stated above, at 5:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
1 yr
Gen C.
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Chronic Interstitial Nephritis
(Duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? 1220
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinically
(Signed) Henry Gaugh M.D.
2/17, 1928 (Address) Liberty Cemetery

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Woodlawn Cem. | DATE OF BURIAL: Feb 18 1928

20. UNDERTAKER: Mrs. C. L. Foster | ADDRESS: K. C. Mo.

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.

WRITE PLAINLY, WITH INDELIBLE INK—THIS IS A PERMANENT RECORD

391