

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

Do not use this space.

41021

1. PLACE OF DEATH

County Jackson
Township New
City N. C. Mo. (No. Research Hospital)

Registration District No. 399
Primary Registration District No. 1093

File No. _____
Registered No. 3232 Ward _____

2. FULL NAME

Herbert Lamont Blaker Blaker
(a) Residence. No. 4832 Jamboree St. Ward. 7
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 22, 1874

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
54 3 1

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pa

10. NAME OF FATHER John W Blaker

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Pa

12. MAIDEN NAME OF MOTHER Eva Hermonius

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Pa

14. INFORMANT Mrs Doris Baker
(Address) 4832 Jamboree Ave

15. FILED 12-25-28 M. M. Cross REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 23, 1928

17. I HEREBY CERTIFY That I attended deceased from Nov 2, 1927 to Dec 23, 1928
that I last saw him alive on Dec 23, 1928 and that death occurred, on the date stated above, at 5:00 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrh.
9512
829

CONTRIBUTORY (SECONDARY) Hypertrophy of Heart
(duration) 11 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH? Yes DATE OF _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) David B. Robinson M.D.
12-25-28 (Address) 603 Bryant St. N. C. Mo.

*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 Smithton Mo DATE OF BURIAL Dec 26, 1928

20. UNDERTAKER Mrs C. L. Foster N. C. Mo. ADDRESS _____

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.

1
R. Robinson
W. J. 12 1/2 by 603
Ham - 42/8