

REC'D FEB 15 1939

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

2271
Do not use this space.

PLACE OF DEATH

(a) County GREENE Registration District No. 376
 (b) Township SPRINGFIELD Primary Registration District No. 2001
 (c) City SPRINGFIELD (d) Street No. Springfield Baptist Hospital Registered No. 3
 (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 Infant Daughter of Mr. Mrs. J.W. Baker
 (a) Residence, No. Route # 9 St. GA 9
 (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) Child
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Jan. 1 1939</u>		
7. AGE YEARS <u>0</u>	MONTHS <u>0</u>	DAYS <u>9</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>child</u>		If LESS than 1 day, hrs. or min.
9. Industry or business in which work was done, as saw mill, bank, etc.		11. Total time (years) spent in this occupation
10. Date deceased last worked at this occupation (month and year)		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Springfield, Mo.</u>		
FATHER	13. NAME <u>J.W. Baker</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Enid Oklahoma</u>	
MOTHER	15. MAIDEN NAME <u>Luvinia Mock</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Springfield, Missouri</u>	
17. INFORMANT <u>J.W. Baker</u> (ADDRESS) <u>Route # 9</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Greenlawn</u> DATE <u>Jan. 1 1939</u>		
19. FUNERAL DIRECTOR (NAME) <u>H.H. Logmeyer</u> (ADDRESS) <u>Springfield Mo.</u>		
20. FILED <u>Jan 1 1939</u> <u>Chas A. George</u> Local Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 1 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 1 1939 to Jan 1 1939
 I last saw her alive on Jan 1 1939 Death is said to have occurred on the date stated above, at 12:00 PM
 The principal cause of death and related causes of importance were as follows:
(Infant Remains)
 Date of onset 1601

Other contributory causes of importance:

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

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) Richard Meyer, M. D.
 (Address) Springfield 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.

STATEMENT BY LICENSED EMBALMER
OF THE STATE OF ILLINOIS

1678

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 _____

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

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.

Vertical text on the right edge of the page, including "STATEMENT BY LICENSED EMBALMER" and "OF THE STATE OF ILLINOIS".

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

2271
Do not use this space.

1. PLACE OF DEATH
 (a) County Greene Registration District No. 318
 (b) Township _____ Primary Registration District No. 2001 Registered No. 3
 (c) City Springfield (d) Street No. _____ 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 Infant daughter of Mrs. J. W. Bauer
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED child
 (For the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
0 0 0

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 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) _____

FATHER 13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____
 18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19 _____

19. FUNERAL DIRECTOR (ADDRESS) _____
Mavis 39 Char. St.
Local Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-1 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____
 I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:
Infantile cerebral meningitis
1/6/39
 Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

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) C. Bertam Meyers M.D.
 (Address) Springfield Mo

SUPPLEMENT

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAWS.

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.

S-2271