

1939 MAR 9

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

5476  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 395  
 (b) Township J.P. Primary Registration District No. 11602 Registered No. 675  
 (c) City J.E. mo (d) Street No. 704 Cherry 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

William Baker  
 (a) Residence, No. 704 Cherry 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 male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) unknown

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-11-39

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

22. I HEREBY CERTIFY, That I attended deceased from 2-6-39 19..... to 2-11-39 19.....

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) oct-13-1865

I last saw him alive on 2-11-39 19..... Death is said to have occurred on the date stated above, at 2 P.M.

7. AGE	YEARS	MONTHS	DAYS	IF LESS THAN 1 day, hrs. or min.
	<u>73.</u>	<u>3</u>	<u>28</u>	

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none  
 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 1

Carcinoma of Prostate Date of onset \_\_\_\_\_  
51

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas

Other contributory causes of importance:

13. NAME Edwin Baker

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) England

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? NO

15. MAIDEN NAME unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

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.

17. INFORMANT (ADDRESS) Record Clerk, H.C. Gen Hosp

18. BURIAL, CREMATION, OR REMOVAL Secular Cem, 2-18-39

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS) Peter B. Hopkins, 536 Campbell St

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_, so, specify \_\_\_\_\_  
 (Signed) P. De Manno M. D.  
Supt. H.C. Gen Hosp  
J.E. mo

20. FILED 2/17 1939 M. M. Brown Local Registrar.

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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**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.**