

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4047

1. PLACE OF DEATH:

(a) County Jackson **NOV 14 1939**

(b) City or town Kansas City, Mo.

(c) Name of hospital or institution: 821 Fuller Ave. **2**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 40 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. 821 Fuller
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Jacob H Baker **260**

(b) If veteran, name war None

3. (c) Social Security No. None

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

6. (b) Name of husband or wife Grace Baker 6. (c) Age of husband or wife if alive -- years

7. Birth date of deceased Nov. 23, 1868
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

70 10 28 _____ hr. _____ min.

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

10. Usual occupation Merchant

11. Industry or business Hardware

12. Name Unknown Unknown

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

14. Maiden name Unknown

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

16. (a) Informant's own signature Francis Baker

(b) Address 821 Fuller, K.C. Mo.

17. (a) Burial (b) Date thereof Oct. 23-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hills Cemetery

18. (a) Signature of funeral director C.H. Blackman & Son, Inc.

(b) Address 2825 Indep. Blvd, K.C. Mo.

19. (a) 10/22/39 (b) M. M. Browne
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 21
year 1939 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from October 18, 1939, to Oct 21, 1939
that I last saw him alive on October 21, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death: Gastrointestinal ulcers **4 days**

Due to Gastritis **11/7/39**

Due to _____

Other conditions Chronic Gastritis **1 yr**
(Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy None

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) Not

(b) Date of occurrence _____

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

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

While at work? _____ (Specify type of place) (e) Manner of injury _____

23. Signature R. P. Allashan (M. D. or other) **1**

Address 6045 East 15th St Date signed 10-23-39

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.