

No. 2  
1-10-39  
-17-39  
X21492

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **37905**  
**4503**  
Registrar's No.

Registration District No. **399** Primary Registration District No. **1002**

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
K.C. General Hospital No. 1.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 days (Specify whether  
33 years (Specify whether  
In this community. 33 years  
years, months or days)

3. (a) PRINT FULL NAME THOMAS P. BALDWIN  
3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Nancy Baldwin 6. (c) Age of husband or wife if alive 68 years  
7. Birth date of deceased September 23, 1865  
(Month) (Day) (Year)

8. AGE: Years 75 Months 2 Days 2 If less than one day  
hr. min.

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

10. Usual occupation Clerk, election commissioner

11. Industry or business

MOTHER FATHER { 12. Name Caleb Baldwin  
13. Birthplace Don't know  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Pinckard  
15. Birthplace Don't know  
(City, town, or county) (State or foreign country)

16. (a) Informant Nancy Baldwin  
(b) Address 3911 Paseo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-40  
(Month) (Day) (Year)  
(c) Place: burial or cremation Butler, Mo.

18. (a) Signature of funeral director Freeman Mortuary  
(b) Address 104 West 42nd Street

19. (a) 11-26-40 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3911 Paseo  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 25th  
year 1940 hour 2:00 minute A. M.

21. I hereby certify that I attended the deceased from 11-23-40, 19\_\_\_\_, to 11-25-40, 19\_\_\_\_;  
that I last saw him alive on 11-25-40, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac decompensation

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Under conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(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) Means of injury \_\_\_\_\_  
23. Signature Wm. R. Shaw (M. D. or other)  
Address Mo. Mo. Date signed \_\_\_\_\_

**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

*Clarence W. Childs*

Licensed Embalmer No.

*3473*

P.O. Address

*K. E. No.*

**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.**