

D MAR 19 1943

Registration District No. 170

Primary Registration District No. 3033 5630

Registrar's No.

1. PLACE OF DEATH:

(a) County Laclede
(b) City or town Lebanon mo Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1 Lebanon Road
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether

In this community..... years, months or days) (Specify whether

3. (a) PRINT FULL NAME HARRY RUSSEL BAKER

3. (b) If veteran, name war none 3. (c) Social Security No.....

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

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

7. Birth date of deceased nov. 15 1919
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
23 3 10 hr. min.

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

10. Usual occupation Laborer

11. Industry or business

MOTHER FATHER
12. Name Claud Baker
13. Birthplace Dixon mo (City, town, or county) (State or foreign country)
14. Maiden name Livia Hoskins
15. Birthplace Lewis Co mo (City, town, or county) (State or foreign country)

16. (a) Informant Claud Baker
(b) Address Lebanon mo.

17. (a) Burial (b) Date thereof Feb. 27, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation City Cemetery Lebanon mo

18. (a) Signature of funeral director W. E. Holman
(b) Address Lebanon mo.

19. (a) 2-27-43 (b) Grace Roper
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Laclede 53
(c) City or town Lebanon R.R. # 2 3
(If outside city or town limits, write "RURAL")
(d) Street No..... (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country..... 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 25
year 1943 hour 1 minute 40 A.M.

21. I hereby certify that I attended the deceased from Feb. 25
1943, to Feb. 25, 1943
that I last saw him alive on Feb. 25, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebratory failure Duration
Due to strenua
Due to catarrhal pneumonia
Other conditions Hypertension
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....
PHYSICIAN

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)
(c) Means of injury.....
23. Signature Alvin H. Anson (M. D. or other) D.O.
Address 109 Monroe Lebanon Date signed 2/26/43

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

RECEIVED

District Health Officer No. *Laclede County Health Unit*
District File Number *2-43-31*
Date Filed *3-16-43*

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 *Dorsey M. Howe*
Licensed Embalmer No. *4222*
P. O. Address *Lebanon Mo.*

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10603

Registration District No. 170

Primary Registration District No. 330

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Laclede

(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

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

In this community _____ years, months or days (Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Harry Russell Baker

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased not 10/19/1910
(Month) (Day) (Year)

8. AGE: Years 23 Months 3 Days 19 min. no.
If less than one day _____ min.

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

10. Usual occupation _____

11. Industry of business _____

MOTHER FATHER { 12. Name _____

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

{ 14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day 08 Year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him/her alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic
myocardial infarction

Due to Uremia

Due to Cataractal glaucoma
chronic glaucoma

Other conditions Hypertension
(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 Arthur B. Krueger (M. D. or other) P.O.
Address Lebanon, Mo. Date signed 5/6/43

SUPPLEMENTARY

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

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

S-10653