

1. PLACE OF DEATH:
(a) County Andrew
(b) City or town Savannah mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Dr. Nichols Sanatorium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 days (Specify whether
In this community 12 days years, months or days)

3. (a) PRINT FULL NAME FERRY, BAKER ERVIN
8. (b) If veteran, name war _____ 8. (c) Social Security No. 1

4. Sex female 5. Color or race white
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan 11 - 1887
(Month) (Day) (Year)

8. AGE: Years 56 Months 10 Days 3 If less than one day _____ hr. _____ min.

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

10. Usual occupation House Wife

11. Industry or business _____
MOTHER FATHER { 12. Name John E Baker
13. Birthplace Ill.
14. Maiden name MARCA RABY
15. Birthplace unknown Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Louis Eggen
(b) Address Champaign Ill.
17. (a) Removal (b) Date thereof 11-15-43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation pergo Ill.
18. (a) Signature of funeral director E. E. Breit
(b) Address Savannah mo
19. (a) 11-15-1943 (b) J. H. Fitchman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County 999
(c) City or town Champaign (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 14
year 1943 hour 1 minute 28 P.M.
21. I hereby certify that I attended the deceased from Nov 3, 1943 to Nov 14, 1943
that I last saw her alive on Nov 14, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death 1 Diabetic Coma Duration _____
2 Hypertension
3 Aortic Stenosis
Due to removed breast and
Due to malignant lymph gland
in left axilla
Other conditions 50
(Include pregnancy within 3 months of death)

PHYSICIAN _____
Major findings: Carcinoma of
left breast and lymph
glands in left
axilla
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) _____
(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 J. H. Manning (M. D. or other) _____
Address Savannah mo Date signed 11/14/43

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.

JAN 24 1944

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 E. C. Breit
Licensed Embalmer No. 2650
P. O. Address Savannah Ga

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.