

**FILED APR 10 1944**

Registration District No. **1000**

Primary Registration District No. **1000**

Registrar's No. **368**

1. PLACE OF DEATH:  
(a) County **Duchesne**  
(b) City or town **St. Joseph**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Mary Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community **24 days** years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **MO** (b) County **Clay**  
(c) City or town **Liberty MO**  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME **Maymie Alice Baker**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **M /**  
6. (b) Name of husband **Dorian Baker** 6. (c) Age of husband or wife if alive **27** years  
7. Birth date of deceased **Sept 5 1921**  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months **21** Days **6** 8 hr. \_\_\_\_\_ min. If less than one day

9. Birthplace **Kallitown MO**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

MOTHER FATHER { 11. Industry or business \_\_\_\_\_  
12. Name **Fred McCarney**  
13. Birthplace **Kallitown MO**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Erma Cox**  
15. Birthplace **Netherton MO**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Dorian Baker**  
(b) Address **Liberty MO**

17. (a) **Recessed** (b) Date thereof **3-16-1944**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Wingston MO**

18. (a) Signature of funeral director **Cramer Clark**  
(b) Address **Wingston MO**

19. (a) **3-16-44** (b) **Alse Hergoy**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **March** day **13**  
year **1944** hour **3** : **40** minute **P** M.  
21. I hereby certify that I attended the deceased from **Mar. 13**, 1944, to **March 13**, 1944;  
that I last saw h. or w. alive on **March 13**, 1944;  
and that death occurred on the date and hour stated above.

Immediate cause of death **acute cardiac Dilatation**  
Duration \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions **acute Bi-lateral Salpingitis**  
(Include pregnancy within 3 months of death)

Major findings: **Salpingitis**  
Of operations **Pelvic surgery; bi-lateral Salpingitis**  
Of autopsy \_\_\_\_\_  
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) \_\_\_\_\_  
(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 **2 D.O.**

23. Signature **[Signature]** (M. D. or other) **D.O.**  
Address **823 3rd St Joseph Mo** Date signed **3/13/44**

WHITE PAPER - USE UNFADING BLACK INK - MAKE A PERMANENT RECORD

2  
43  
39  
35697

**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

*Loramer Clark*

Licensed Embalmer No.....

*3257*

P. O. Address.....

*Kingston MD*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

Registration District No. 40 Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town Joseph  
(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

3. (a) PRINT FULL NAME Maymie A. Baker  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 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 Sept 5 1914  
(Month) (Day) (Year)

8. AGE: Years 21 Months 6 Days \_\_\_\_\_ If less than one day, \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Mo.

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_ (City, town, or county) (State or foreign country)  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

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

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 \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH Month March 13  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death acute cardiac Duration  
distention 139a

Due to \_\_\_\_\_  
Due to acute B1 - external  
salpingitis

Other conditions Pelvic abscess  
(include pregnancy within 3 months of death)  
Major findings: the lateral salpingelitis PHYSICIAN  
Of operations Laboratory report  
mixed Infection  
Of autopsy \_\_\_\_\_  
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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Date signed \_\_\_\_\_

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

SUPPLEMENTAL

10413