V. S. No. 2
00M—2-43
ev. 5-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

26327

State File No.

FILED SEP 1 1945

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3400

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: 508 Knickerbocker Place /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution no. (Specify whether
In this community 30 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City, 3
(If outside city or town limits, write "RURAL")

(d) Street No. 508 Knickerbocker Place 8
(If rural, give location)

(e) Citizen of foreign country? no. (Yes or No) 0

If yes, name country x

3. (a) PRINT FULL NAME Miss Elizabeth Topliff Baker

3. (b) If veteran, name war no.

3. (c) Social Security No. no.

4. Sex Female /

5. Color or race White

6. (a) Single, widowed, married, divorced Single /

6. (b) Name of husband or wife Mrs. Eleanor C. Walton

6. (c) Age of husband or wife if alive x years

7. Birth date of deceased January (Month) 22 (Day) 1869 (Year)

8. AGE: Years 76 Months 6 Days ~~22~~ 21 If less than one day hr. min.

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

10. Usual occupation at home,

11. Industry or business x

FATHER
12. Name James L. Baker,
13. Birthplace Massachusetts / (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Susan Farris,
15. Birthplace Massachusetts / (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Eleanor C. Walton,
(b) Address 508 Knickerbocker Place. K. C., Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-17-45 (Month) (Day) (Year)
(c) Place: burial or cremation mt. Washington

18. (a) Signature of funeral director Stine & McClure,
(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 8-14-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 13
year 1945 hour 12:47 minute P M.

21. I hereby certify that I attended the deceased from 1941 to 1945
Last 3 years 19 to Aug 13 45
that I last saw her alive on Aug 13 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Bronchial

Due to Old age - Infirmity arteriosclerosis

~~Due to~~ High blood pressure

Other conditions She was in her
(Include pregnancy within 3 months of death)
apt. following fractured

Major findings: Of operations hip. ever since

Of autopsy no

107

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: X

(a) Accident, suicide, or homicide (specify) X

(b) Date of occurrence X

(c) Where did injury occur? Several yrs. ago (City or town) (County) (State)

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

While at work? (e) Means of injury 0

23. Signature J. J. Beatty (M.D. or other)

Address 1202 Waldheim Bldg Date signed

(Licensed Embalmer's Statement on Reverse Side)

J. J. Beattie
Wallheim Bg

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. M. Plank

Licensed Embalmer No. 1848

P. O. Address K. C. 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.