

FILED OCT 12 1945
Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Luke's Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 Days 12 Hours**
In this community **2 Days 12 Hours**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Illinois** (b) County **999**
Collinsville
(c) City or town **Collinsville**
(If outside city or town limits, write "RURAL")
(d) Street No. **Caseville Road**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No) **2**
If yes, name country _____

3. (a) PRINT FULL NAME **James Edward Baker**

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 **single**

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

7. Birth date of deceased **Sept. 30 1945**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
2 12 hr. min.

9. Birthplace **St. Louis Mo. U**
(City, town, or county) (State or foreign country)

10. Usual occupation **infant**

11. Industry or business _____

12. Name **James E. Baker**

13. Birthplace **Lansing Mich. I**
(City, town, or county) (State or foreign country)

14. Maiden name **Myra Miller**

15. Birthplace **St. Louis Mo. U**
(City, town, or county) (State or foreign country)

16. (a) Informant **James E. Baker**

(b) Address **Caseville Rd. Collinsville**

17. (a) **burial** (b) Date thereof **10-4-1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New St. Marcus**

18. (a) Signature of funeral director **W. Schumacher**

(b) Address **3013 Meramec**

19. (a) **OCT 3 1945** (Date received local registrar)
J. F. Bredek (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **3**
year **1945** hour **11** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **September 30**, 19 **45**, to **October 3**, 19 **45**;
that I last saw him alive on **Oct. 3**, 19 **45**;
and that death occurred on the date and hour stated above.

Immediate cause of death **intercerebral hemorrhage** Duration **3 days**

Due to **seizure**

Due to **160**

Other conditions **hypopyemia** 1 day
(Include pregnancy within 3 months of death)

Major findings: Of operations **Y**

Of autopsy **pericardial effusion**

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 **0**

23. Signature **H. Gerwacht** (M. D. or dentist)

Address **2720 Washington** Date signed **10/3/45**

PHYSICIAN

Underline the cause to which death should be charged statistically.

St. Roch
Permanently

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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..... *Francis Williamson*
..... Licensed Embalmer No. *3565*
..... P. O. Address: *St Louis, 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.