

Registration District No. **5** Primary Registration District No. **5572**

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Rural Prairie
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Jackson County E. Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 6 days
(Specify whether years, months or days)
 In this community 43 yrs

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. 8001 Michigan **8**
(If rural, give location)
 (e) Citizen of foreign country? 1
(Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME James Baker

3. (b) If veteran, name war No
3. (c) Social Security No. 496-10-1841

4. Sex Male **5. Color or race** Wh.
6. (a) Single, widowed, married, divorced I

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

7. Birth date of deceased Sept. 29th 1867
(Month) (Day) (Year)

8. AGE: Years 78 Months 4 Days 13
 If less than one day hr. _____ min. _____

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

10. Usual occupation Retired

11. Industry or business _____

12. Name Benjamin Baker

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

14. Maiden name Carlyn Mattern

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

16. (a) Informant Hospital records

(b) Address Rt #40 Juds. Mo.

17. (a) Burial Lees Summit Mo
(Burial, cremation, or removal) **(b) Date thereof** 2-14-46
(Month) (Day) (Year)

(c) Place: burial or cremation Lees Summit Mo

18. (a) Signature of funeral director W. B. Longford

(b) Address Lees Summit Mo

19. (a) 2/15/46 **(b)** John E. Baker
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month February day 12th
 year 1946 hour 10 minute 30 A.M.

21. I hereby certify that I attended the deceased from 2-6-46, 19____, to 2-12-46, 19____;
 and that death occurred on the date and hour stated above.

that I last saw him alive on 2-12-46, 19____;
 Immediate cause of death: Coronary Decompensation
hypertension
Arteriosclerosis.

Due to _____
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: _____
 Of operations _____
 Of autopsy 97

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? _____

Signature [Signature] (Specify type of place)
(M. D. or other)
 Address 200 Plaza med Bldg Date signed 2/19/46

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

12374

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

W B Langford

Licensed Embalmer No. *3823*

P. O. Address *Fees Summit*

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

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