

**FILED DEC 23 1946**  
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:  
**Homer G Phillips Hospital 0**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **2 days**  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME **Thomas Baker**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **Male 2** 5. Color or race **Col** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_

7. Birth date of deceased **July 5 1872**  
(Month) (Day) (Year)

8. AGE: Years **74** Months **5** Days **10**  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **Florisant Mo 0**  
(City, town, or county) (State or foreign country)

10. Usual occupation **WRITER**

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

12. Name **ROBERT BAKER 1**

13. Birthplace **KY 1**  
(City, town, or county) (State or foreign country)

14. Maiden name **MARIE JENNEY 1**

15. Birthplace **KY 1**  
(City, town, or county) (State or foreign country)

16. (a) Informant **MOLLIE REID 1**

(b) Address **2019 CARR REAR 1**

17. (a) **Burial** (b) Date thereof **DEC 18 1946**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **GREENWOOD CEM 1**

18. (a) Signature of funeral director **J. A. Year**

(b) Address **2915 FRANKLIN 1**

19. (a) **DEC 18 1946** (b) **J. J. Brebeck**  
(Date received from Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**  
(c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **2019 rear Carr 9**  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **15** year **1946** hour **7** minute **10** A. M.

21. I hereby certify that I attended the deceased from **12-13** 19 **46** to **12-15** 19 **46**  
that I last saw him alive on **Dec. 15** 19 **46**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertensive Cardiovascular with Anasarca**  
Duration **Undet.**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions **None**  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

(c) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

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 **E. B. Williams** (M. D. or other) \_\_\_\_\_

Address **2601 N. Webster** Date signed **12/16/46**

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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.....

Licensed Embalmer No. 2915

P. O. Address Franklin

**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.**