

FILED MAR 21 1947

State File No. _____

Registration District No. _____

Primary Registration District No. 4362

Registrar's No. 27

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Morehouse
(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) 1
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County New Madrid
(c) City or town Morehouse
(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 JAMES VAL BAKER

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Verna 6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased Dec 4 1865
(Month) (Day) (Year)

8. AGE: Years 80 Months 11 Days 10 If less than one day hr. _____ min. _____

9. Birthplace Harrisburg (City, town, or county) Ill (State or foreign country)

10. Usual occupation Ret. Lawyer

11. Industry or business _____

12. Name DK 9

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

14. Maiden name Susan 9

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

16. (a) Informant Mrs J.V. Baker
(b) Address Morehouse Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-46
(Month) (Day) (Year)

(c) Place: burial or cremation Sikeston Mo
(d) Signature of funeral director Welsh Funeral Home
(e) Address Sikeston Mo

19. (a) 3-12-47 (Date received local registrar) Thomas M. Phettes Jr (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 14 year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h_____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 1 week

Due to _____

Due to _____

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

Major findings: Of operations GBA

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 _____

23. Signature Jm. Davis Jr (M. D. or other) _____
Address Morehouse Mo Date signed 12-18-46

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

42534

220

RECEIVED

District Health Office No. 2

District File Number 347-361

Date 3-14-47

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..... Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Sikeston 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.

11-51-E