

No. 2
-12-45
-17-39
X47070

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32298

State File No.

FILED OCT 4 1947

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 8956

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Barnes Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 29 Days (Specify whether years, months or days)

3. (a) PRINT FULL NAME Irma Cecelia Baker

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Keith Baker

6. (c) Age of husband or wife if alive 34 years

7. Birth date of deceased May 26 1915
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

32 3 28 hr. min.

9. Birthplace Elvins Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER

12. Name Daniel M. Henderson

13. Birthplace St. Francois Co., Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Nora E. Keay

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

16. (a) Informant Mrs. Wm. Sikes

(b) Address Bismarck, Mo.

17. (a) Burial (b) Date thereof 9-27-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bismarck, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) SEP 25 1947 (b) J. F. Breicat
(Date received from physician) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois 94

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

(d) Street No. N.R. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 27
year 1947 hour 10 minute -9 M.

21. I hereby certify that I attended the deceased from August 28, 1947, to Sept 24, 1947, that I last saw her alive on Sept 24, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death Amoebic colitis

Due to Amoebic abdominal abscess

Due to Adenocarcinoma of the Cecum

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations H/O

Of autopsy As above

Duration

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 F. L. Bradley (M. D. or other)

(Address Barnes Hospital) Date signed 9/25/47

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..... *J. W. Wilkinson*

Licensed Embalmer No..... *3575*

P. O. Address.....

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.