

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

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 11 1949

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42949**
Registrar's No. **8**

Registration District No. **297**

Primary Registration District No. **6021**

1. PLACE OF DEATH:

(a) County **Ray**
(b) City or town **Rural - GRAPE GROVE**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Southwest of Pocat, Mo.
(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 **Lifotimo** years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO.** (b) County **Ray** **99**
(c) City or town **Rural** **0**
(If outside city or town limits, write "RURAL") **0**
(d) Street No. **Southwest of Pocat, Mo.**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No) **0**
If yes, name country _____

3. (a) PRINT FULL NAME **JOHN WILLIAM BAKER**

3. (b) If veteran, name war **Y** 3. (c) Social Security No. **X**

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

6. (b) Name of husband or wife **Stalle Baker** 6. (c) Age of husband or wife if alive **60** years

7. Birth date of deceased **December 6 1878**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 11 12 X hr. X min.

9. Birthplace **Carroll Co., Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farming**

11. Industry or business **Farmer**

12. Name **John Baker**

13. Birthplace **Unknown Va.**
(City, town, or county) (State or foreign country)

14. Maiden name **Susan Brock Baker**

15. Birthplace **Unknown Va.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Melbin Baker**

(b) Address **Rural - Richmond, Mo.**

17. (c) **Burial** (b) Date thereof **Nov. 20, 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Olivet Cemetery**

18. (a) Signature of funeral director **Gene C. Michael**

(b) Address **Braymer, Mo.**

19. (a) **Jan 12 - 1949** (b) **Melbin Baker 273**
Date received local registrar (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **11** day **18**
year **1948** hour **5** minute **15** M.

21. I hereby certify that I attended the deceased from **10 26**, 19 **48**, to **11-18**, 19 **48**
that I last saw him alive on **11-17**, 19 **48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of Stomach with massive Hemorrhage** **3 2 hrs**
Duration

Due to _____
Due to _____

Other conditions **River Melitosis**
(Include pregnancy within 3 months of death)

Major findings: **5 ft 46 lb**
Of operations _____
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)
(c) Means of injury **0**

23. Signature **J. H. Wilson M.D.** (other) _____
Address **P.O. Box 273** Date signed **11-23-48**

RECEIVED

District Health Officer No. _____

District File Number _____

Date Filed 4-8-49

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 Gene C. Michael

Licensed Embalmer No. 4340

P. O. Address Brymer, 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.