

FILED AUG 24 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26745
 BIRTH NO. _____ REG. DIST. NO. 137 PRIMARY REG. DIST. NO. 4219 Registrar's No. 186

1. PLACE OF DEATH a. COUNTY <u>Henry</u>		2. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Johnson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Windsor</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Leston</u>	
c. LENGTH OF STAY (In this place) <u>7 days</u>		d. STREET ADDRESS (If rural, give location) <u>R.R. #2 Leston, Missouri</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Windsor Community Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Anna</u>	b. (Middle) <u>Mary</u>	c. (Last) <u>Baker</u>	4. DATE OF DEATH (Month) (Day) (Year)
				<u>August 7, 1949</u>

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced ?</u>	8. DATE OF BIRTH <u>September 14, 1871</u>	9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months Days	IF UNDER 2 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaking</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Joseph C. Baker</u>	13b. MOTHER'S MAIDEN NAME <u>Johanna Dalgoth</u>	14. NAME OF HUSBAND OR WIFE <u>Divorced</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Will Baker</u>	ADDRESS <u>Mals, Missouri</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hy Pertension</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>331X</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 7-21, 1949, to 8-7, 1949, that I last saw the deceased alive on 8-7, 1949, and that death occurred at 7A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Ruby Jordan M.D.</u>	23b. ADDRESS <u>Windsor Mo</u>	23c. DATE SIGNED <u>8-12-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>8-12-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>High Point Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Johnson Co. Missouri</u>
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DATE REC'D BY LOCAL REG. <u>Aug-12-49</u>	REGISTRAR'S SIGNATURE <u>Florence Adair</u>	422	25. FUNERAL DIRECTOR'S SIGNATURE <u>W. B. ...</u>	ADDRESS <u>Warrensburg, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-48

RECEIVED

District Health Officer No. 7,

District File Number 7-49-1002

Date Filed 8-22-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed W. B. Brannigan

Licensed Embalmer No. 5377

P. O. Address Warrensburg, 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.