S. No. 300
v. 10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7970

FILED APR 15 1952

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 339

1. PLACE OF DEATH
a. COUNTY Greene
b. CITY OR TOWN Springfield
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Burge Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY Greene
c. CITY OR TOWN Springfield 0396 0
d. STREET ADDRESS (If rural, give location) 941 W. Chestnut

3. NAME OF DECEASED (Type or Print) a. (First) Artelia b. (Middle) Jane c. (Last) Baker

4. DATE OF DEATH (Month) April (Day) 6 (Year) 1952

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH 11 Feb. 1876
9. AGE (In years last birthday) 76 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY In Home
11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Robert S. Reed
13b. MOTHER'S MAIDEN NAME Sarah Elizabeth Goode
14. NAME OF HUSBAND OR WIFE Deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. Unk
17. INFORMANT'S SIGNATURE OR NAME Sam Jones ADDRESS Springfield, Mo.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis, generalized — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma, left breast — 4 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 170X
20. AUTOPSY? YES ☐ NO ☒

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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 28 March, 1951, *to* 6 April, 1952, *that I last saw the deceased alive on* 5 April, 1952, *and that death occurred at* 10:00 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE Kenneth E. Knott, (Degree or title) M.D.
23b. ADDRESS 1630 N. Jefferson
23c. DATE SIGNED 7 April 52

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8 Apr. 1952
24c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery
24d. LOCATION (City, town, or county) Springfield (State) Mo.

DATE REC'D BY LOCAL REG. 4-9-52
REGISTRAR'S SIGNATURE James R. Ross, M.D.
25. FUNERAL DIRECTOR'S SIGNATURE J.W. Klingner & Co. ADDRESS Springfield, Mo.

(Licensed Embalmer Statement on Reverse Side)

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

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.....

.....,

working under my personal supervision.

Student Embalmer No.....

Signed Warren D. Nollett

Signed.....
Student Embalmer

Licensed Embalmer No. 4005

P. O. Address Springfield Me

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.