

FILED JUN 24 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20150**
4489

BIRTH NO. <u>38181-54</u>		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>4489</u>					
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE				b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Louis</u>				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Louis</u>				2129 0			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Saint Louis Maternity</u>				d. STREET ADDRESS (If rural, give location) <u>5386 Pershing Avenue</u>							
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mark</u>			b. (Middle) <u>Richard</u>			c. (Last) <u>Baker</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>May 18 1954</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>--</u>		8. DATE OF BIRTH <u>May 17 1954</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 12 HRS. Hours Min. <u>23</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>--</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>			11. BIRTHPLACE (City and State or Foreign Country) <u>St Louis Missouri</u>			12. CITIZEN OF WHAT COUNTRY? <u>Missouri</u>		
13a. FATHER'S NAME <u>William Leon Baker</u>				13b. MOTHER'S MAIDEN NAME <u>Annalee Ballard</u>				14. NAME OF HUSBAND OR WIFE <u>Annalee Baker Above add</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>--</u>				16. SOCIAL SECURITY NO. <u>--</u>				17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Annalee Baker Above add</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>This does not mean mode of dying, such as heart failure, asthma, etc. It means the disease, injury or complication which caused death.</u>		MEDICAL CERTIFICATION 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) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH <u>23 hours</u>			
19a. DATE OF OPERATION <u>7/21/54</u>		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
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) (Minute)					
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>7600</u>									
22. I hereby certify that I attended the deceased from <u>May 17 1954</u> to <u>May 18 1954</u> , that I last saw the deceased alive on <u>May 18 1954</u> , and that death occurred at <u>2:18 P.m.</u> , from the causes and on the date stated above.											
23a. SIGNATURE (Degree or title) <u>Charles R. Gulik, M.D.</u>				23b. ADDRESS <u>3720 Washington Blvd.</u>				23c. DATE SIGNED <u>5/19/54</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Remove</u>		24b. DATE <u>5-19-1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Altamont</u>		24d. LOCATION (City, town, or county) (State) <u>Ill</u>					
DATE REC'D BY LOCAL REG. <u>MAY 19 1954</u>				REGISTRAR'S SIGNATURE <u>[Signature]</u>				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Geisking Mortuary Altamont Ill</u>			

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

J. Allen Rawick

Licensed Embalmer No. 4053

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.