

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5516**

FILED MAR 6 1956

BIRTH NO. _____ REG. DIST. NO. 175 PRIMARY REG. DIST. NO. 31-36 Registrar's No. 20

1. PLACE OF DEATH a. COUNTY Lawrence County		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Lawrence	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marionville		c. CITY OR TOWN Marionville	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 50 yrs,		• STREET ADDRESS (If rural, give location) 500 Missouri Avenue	
d. FULL NAME OF HOSPITAL OR INSTITUTION 500 Mo. Ave.			

3. NAME OF DECEASED (Type or Print) a. (First) Henry b. (Middle) Dickson c. (Last) Baxter	4. DATE OF DEATH (Month) (Day) (Year) Feb. 26, 1956
---	---

5. SEX Male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH June 17, 1884	9. AGE (In years last birthday) 71	IF UNDER 1 YEAR Days 8	IF UNDER 4 HRS. Hours 9 Min.
--------------------	-------------------------------	---	---------------------------------------	---	-------------------------------	-------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and State or Foreign Country) Shelbyville, Tenn.	12. CITIZEN OF WHAT COUNTRY? U, S, A.
---	--	--	--

13a. FATHER'S NAME George Baxter	13b. MOTHER'S MAIDEN NAME Mollie Collier	14. NAME OF HUSBAND OR WIFE Sadie Baxter
---	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 500-10-2228	17. INFORMANT'S SIGNATURE OR NAME Mrs. Henry Baxter, Marionville, Mo	ADDRESS
--	--	---	---------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 10 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Terminal of Uremia -		3 years
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypochloremia and DUE TO (c) Encephalomalacia.		
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 446x	20. AUTOPSY? YES <input 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) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I attended the deceased from 1954 to Feb 26, 1956, that I last saw the deceased alive on Feb 26, 1956, and that death occurred at 9:00 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) A. P. Coyle M.D.	23b. ADDRESS Marionville, Mo.	23c. DATE SIGNED 2-27-56
--	--------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Mar. 1-1956	24c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery	24d. LOCATION (City, town, or county) (State) Marionville, Mo.
---	------------------------------	--	---

DATE REC'D BY LOCAL REG. 2-28-56	REGISTRAR'S SIGNATURE Ora Ma Natt	25. FUNERAL DIRECTOR'S SIGNATURE J. B. Burridge	ADDRESS Marionville, Mo.
---	--	--	---------------------------------

(Licensed Embalmer's 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, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
James D. Crafton

Licensed Embalmer No. *460*

P. O. Address *Aurora*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.