

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35648**
5011

FILED NOV 14 1957

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>JACKSON</u>			
b. CITY OR TOWN <u>KANSAS CITY</u>		c. LENGTH OF STAY (in this place) <u>LIFE</u>		c. CITY OR TOWN <u>KANSAS CITY</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>TRINITY LUTHERAN HOSP</u>				STREET ADDRESS (If rural, give location) <u>5337 WAYNE</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>CHARLES</u> b. (Middle) <u>ANTHONY</u> c. (Last) <u>BAKER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>OCT 27 1957</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u>		8. DATE OF BIRTH <u>JUNE 25, 1940</u>	
9. AGE (in years last birthday) <u>17</u>		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) <u>STUDENT</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>KANSAS CITY, MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Boyd M. BAKER</u>			13b. MOTHER'S MAIDEN NAME <u>IRENE M. SHEPARD</u>			14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Boyd M. BAKER</u> ADDRESS <u>5337 WAYNE K.C. MO.</u>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic glomerulonephritis</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. <u>Hypertension with hypertensive heart failure</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Known 3 months</u> <u>59 days</u> <u>2 weeks</u>
19a. DATE OF OPERATION _____		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) _____		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 <u>August 4, 1957</u> to <u>October 27, 1957</u> , that I last saw the deceased alive on <u>October 27, 1957</u> , and that death occurred at <u>8:15 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>G. Comer Bates M.D.</u> (Degree or title) D				23b. ADDRESS <u>329 Arrow Road North Kansas City 16 Mo.</u>		23c. DATE SIGNED <u>Oct. 28/1957</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>OCT. 30, 1957</u>		24c. NAME OF CEMETERY OR CREMATORY <u>GREEN LAWN CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>	
DATE REC'D BY LOCAL REG. <u>10-29-57</u>		REGISTRAR'S SIGNATURE <u>neva Minshall</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>D.W. McComber's Home 1331 Brook Creek</u>		

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
G. Comer Bates



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... *Chester K Brown*

Licensed Embalmer No. *493*

P. O. Address *K E Mc*

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.