

pt. Health,  
& Welfare  
S. Public  
Hth Service

FILED DEC 16 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

44974

STATE FILE NUMBER

Registration District No. 178 Primary Registration District No. 5664 Registrar's No. 109

0564  
S. 3004  
v. 1-57

1. PLACE OF DEATH a. COUNTY <b>Lewis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Lewis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Reddish</b>		c. CITY OR TOWN <b>Canton</b>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Rest Home</b>		d. STREET ADDRESS (If outside, give location) <b>705 College</b>	
Length of stay in 1b <b>30 days</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>Lenna Alice Baker</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>6,</b> Year <b>1957</b>		
First			Middle		
Last			Year		

5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 1, 1887</b>	9. AGE (In years last birthday) <b>70</b>	10. FUNDING YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Registered nurse</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Mo. Meth. Hospital; Clark County, Mo.</b>	11. BIRTHPLACE (City and state or country) <b>St. Joseph, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Henry B. Baker</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah E. Ball</b>	14. NAME OF HUSBAND OR WIFE <b>Single</b>
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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) <b>NO</b>	16. SOCIAL SECURITY NO. <b>489-361436</b>	17. INFORMANT Address <b>Clyde Richards, Canton, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days.</b>
DUE TO (b) <b>Hypertension</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c)		<b>2 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>331X</b>
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <b>Nov 15 - 1956</b> to <b>Dec 6 - 1957</b> and last saw her alive on <b>Dec 4 - 57.</b> Death occurred at <b>7:00 PM</b> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>Harvey Davis M.D.</b>	22b. ADDRESS <b>Canton Mo.</b>	22c. DATE SIGNED <b>Dec 7 - 1957</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Dec. 8, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Day Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Winchester, Clark Co. Mo.</b>
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24. FUNERAL DIRECTOR <b>Earl H. Berkley, Canton, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>12-9-57</b>	26. REGISTRAR'S SIGNATURE <b>P.W. Jennings, M.D.</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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FEB 18 1958

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

Signature 

Licensed Embalmer No. 2615  
P. O. Address Carroll 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.