

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-006988  
STATE FILE NUMBER

FILED MAR 5 - 1958

1003

2050

Registration District No. 318 Primary Registration District No.

Registrar's No.

300  
-57

|                                                                                                                                                                                                                                                            |  |                                                                                                                             |                                                                                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY                                                                                                                                                                                                                             |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY |                                                                                                   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>St. Louis</b>                                                                                                                                                                   |  | c. CITY OR TOWN <b>St. Louis</b>                                                                                            |                                                                                                   |
| Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                       |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                        |                                                                                                   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>                                                                                                                                                    |  | Length of stay in lb<br><b>30 yrs.</b>                                                                                      |                                                                                                   |
| d. STREET ADDRESS<br><b>4242 Fairfax</b>                                                                                                                                                                                                                   |  | (If outside, give location)<br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>        |                                                                                                   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Norman Baker</b>                                                                                                                                                                                              |  | 4. DATE OF DEATH<br>Month <b>2</b> Day <b>18</b> Year <b>58</b>                                                             |                                                                                                   |
| 5. SEX <b>Male</b>                                                                                                                                                                                                                                         |  | 6. COLOR OR RACE <b>Negro</b>                                                                                               |                                                                                                   |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                                                                                |  | 8. DATE OF BIRTH<br><b>Jan. 3, 1898</b>                                                                                     |                                                                                                   |
| 9. AGE (In years last birthday)<br><b>60</b>                                                                                                                                                                                                               |  | F UNDER 1 YEAR<br>Months <b>1</b> Days <b>15</b>                                                                            |                                                                                                   |
| IF UNDER 24 HRS.<br>Hours <b></b> Min. <b></b>                                                                                                                                                                                                             |  |                                                                                                                             |                                                                                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>                                                                                                                                              |  | 10b. KIND OF BUSINESS OR INDUSTRY                                                                                           |                                                                                                   |
| 11. BIRTHPLACE (City and state or country)<br><b>Blytheville, Arkansas</b>                                                                                                                                                                                 |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                                                             |                                                                                                   |
| 13a. FATHER'S NAME<br><b>Stonewall Baker</b>                                                                                                                                                                                                               |  | 13b. MOTHER'S MAIDEN NAME<br><b>Lizzie Hickman</b>                                                                          |                                                                                                   |
| 14. NAME OF HUSBAND OR WIFE<br><b>Addie Baker</b>                                                                                                                                                                                                          |  |                                                                                                                             |                                                                                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                  |  | 16. SOCIAL SECURITY NO.<br><b>494-03-8863</b>                                                                               |                                                                                                   |
| 17. INFORMANT<br><b>Addie Baker</b>                                                                                                                                                                                                                        |  | Address<br><b>4242 Fairfax Ave.</b>                                                                                         |                                                                                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>G.I. Hemorrhage</b>                                                                                                    |  |                                                                                                                             | INTERVAL BETWEEN ONSET AND DEATH<br><b>14 days</b>                                                |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Uremic enterocolitis</b>                                                                                                                       |  |                                                                                                                             | <b>5 mos.</b>                                                                                     |
| DUE TO (c) <b>571.1</b>                                                                                                                                                                                                                                    |  |                                                                                                                             |                                                                                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Hepatic Coma</b>                                                                                                   |  |                                                                                                                             | 19. WAS AUTOPSY PERFORMED?<br>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.)                                |                                                                                                   |
| 20c. TIME OF INJURY<br>Hour <b></b> Month, Day, Year<br>a.m. <b></b> p.m. <b></b>                                                                                                                                                                          |  |                                                                                                                             |                                                                                                   |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT 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                                                                                                                |                                                                                                   |
| 21. I attended the deceased from <b>2-4-58</b> , to <b>2-18-58</b> and last saw <sup>her</sup> him alive on <b>2-18-58</b><br>Death occurred at <b>2:30</b> <b>A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated. |  |                                                                                                                             |                                                                                                   |
| 22a. SIGNATURE<br><b>G. H. Wood</b> (Degree or title) <b>M.D.</b>                                                                                                                                                                                          |  | 22b. ADDRESS<br><b>2601 Whittier Street</b>                                                                                 |                                                                                                   |
| 22c. DATE SIGNED<br><b>2-18-58</b>                                                                                                                                                                                                                         |  |                                                                                                                             |                                                                                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>                                                                                                                                                                                                |  | 23b. DATE<br><b>Feb. 24, 1958</b>                                                                                           |                                                                                                   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Washington Park</b>                                                                                                                                                                                               |  | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis Co. Mo.</b>                                                   |                                                                                                   |
| 24. FUNERAL DIRECTOR<br><b>J. H. Randle &amp; Son</b>                                                                                                                                                                                                      |  | 25. DATE RECD. BY LOCAL REG.<br><b>FEB 20 '58</b>                                                                           |                                                                                                   |
| ADDRESS<br><b>3133 Bell Ave.</b>                                                                                                                                                                                                                           |  | 26. REGISTRAR'S SIGNATURE<br><b>Paul Smith</b>                                                                              |                                                                                                   |

(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 Part 18. No symptoms will be stated. All diseases in Part 1 must be causally related.

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 *Esther A. Harris* .....

Licensed Embalmer No. *4458*  
P. O. Address *4181 Wash*

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.