

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038553
STATE FILE NUMBER

FILED OCT 24 1958 Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 193

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| 1. PLACE OF DEATH a. COUNTY SCOTT | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY SCOTT | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SIKESTON | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN SIKESTON 1003 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION MO. DELTA COMMUNITY HOSPITAL | | Length of stay in lb 9 days | d. STREET ADDRESS (If outside, give location) 821 Lake Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First Middle Last JAMES LEONARD BAKER | | | 4. DATE OF DEATH Month Day Year 10-9-1958 | | |
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| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-28-1898 | 9. AGE (In years last birthday) 60 | IF UNDER 1 YEAR Months Days 2 10 | 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) SHOE FACTORY | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) TENNESSEE | 12. CITIZEN OF WHAT COUNTRY? U.S. |
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| 13a. FATHER'S NAME VINCENT BAKER | 13b. MOTHER'S MAIDEN NAME LOLA LIVINGSTON | 14. NAME OF HUSBAND OR WIFE MAE HEATH BAKER |
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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) | 16. SOCIAL SECURITY NO. 492-01-7917 | 17. INFORMANT Address WIFE, MAE BAKER, SIKESTON, MISSOURI |
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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) CEREBRAL HEMORRHAGE Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) ART. SCLEROSIS DUE TO (c) 331X | | INTERVAL BETWEEN ONSET AND DEATH 8 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Art. scler. heart dis - | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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| 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.) |
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| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. |
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| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 |
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| 21. I attended the deceased from 7 1957 to 10.9.58 and last saw ^{him} alive on 10.8.58 Death occurred at 7 1957 m on the date stated above; and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE Carl G. Popp M.D. (Degree or title) | 22b. ADDRESS SIKESTON, MO. | 22c. DATE SIGNED 10.9.58 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE 10-12-58 | 23c. NAME OF CEMETERY OR CREMATORY GARDEN OF MEMORIES | 23d. LOCATION (City, town, or county) (State) SIKESTON MO |
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| 24. FUNERAL DIRECTOR ADDRESS Welsh Funeral Home Sikeston Mo | 25. DATE RECD. BY LOCAL REG. 10-17-58 | 26. REGISTRAR'S SIGNATURE Miss Ella Hunter |
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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DATE RECEIVED 10-20-58

SCOTT CO. HEALTH DEPT.

CO. FILE No. 1058-244

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 Raymond Crews

Licensed Embalmer No. 3467

P. O. Address St. Kerston 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.