

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008184

STATE FILE NUMBER

FILED MAR 11 1959 Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 31

1. PLACE OF DEATH a. COUNTY Vernon		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Bates	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Butler
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital #3		Length of stay in 1b 10-1	d. STREET ADDRESS (If outside, give location) 103 E. Pleasant
3. NAME OF DECEASED (Type or print) First Middle Last Alma E. Baker			4. DATE OF DEATH Month Day Year 3- 3- 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-25-1871
10a. USUAL OCCUPATION (Give kind of work done during most of working life) Housewife (retired)		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years birthday) 87
11. BIRTHPLACE (City and state or country) Missouri (Butler, Bates, Co.)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Henry Beard		13b. MOTHER'S MAIDEN NAME Eliza Kretzinger	14. NAME OF HUSBAND OR WIFE Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If unknown, give dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Adm Papers
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia DUE TO (b) Coronary Vessel Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Senil Dementia			INTERVAL BETWEEN ONSET AND DEATH 1 Day Years
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 Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT <input type="checkbox"/> WORK AT WORK	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 _____ to _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE George Esker M.D. (Degree or title)		22b. ADDRESS State Hospital #3	22c. DATE SIGNED 3-3-1959
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 3-5-59	23c. NAME OF CEMETERY OR CREMATORY Oak Hill	23d. LOCATION (City, town, or county) (State) BUTLER MO.
24. FUNERAL DIRECTOR Culver Underwood		25. DATE RECD. BY LOCAL REG. 3-4-1959	26. REGISTRAR'S SIGNATURE Anna J. Ferry

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

(Licensed Embalmer's Statement on Reverse Side)

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

John G. Underwood
Licensed Embalmer No. 3585
P. O. Address Butler, Pa.

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.