

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016985
STATE FILE NUMBER

FILED MAY 19 1959 Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 177

1. PLACE OF DEATH a. COUNTY <i>Cape Girardeau</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>Scott</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Cape Girardeau</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>Farmfelt</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Cape Osteopathic Hosp.</i> Length of stay in lb <i>1 day</i>		d. STREET ADDRESS (If outside, give location) <i>1000</i> Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>JAMES AUGUST BAKER</i>			4. DATE OF DEATH Month Day Year <i>MAY 5 1959</i>
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 8, 1885</i>
9. AGE (In years last birthday) <i>73</i>		IF UNDER 1 YEAR Months Days <i>5 27</i>	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer (Retired)</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>Galma, Mo.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13a. FATHER'S NAME <i>Richard J. Baker</i>	
13b. MOTHER'S MAIDEN NAME <i>Marcella J. Crites</i>		14. NAME OF HUSBAND OR WIFE <i>Elizabeth Baker</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>yes, 1909-1911</i>		16. SOCIAL SECURITY NO. <i>306-28-4885</i>	17. INFORMANT Address <i>Mrs. Elizabeth Baker, Farmfelt Mo.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute circulatory Failure</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Left ventricular hypertrophy & dilatation 2 years</i> DUE TO (c) <i>Arteriosclerotic Heart Disease</i>			INTERVAL BETWEEN ONSET AND DEATH <i>acute</i> <i>Chronic</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the principal disease condition given in PART I (a) <i>Bronchial Asthma Chronic severe</i>			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.) <i>4200</i>		
20c. TIME OF INJURY .Hour Month, Day, Year a.m. p.m.		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 <i>May 4, 1959</i> to <i>May 4, 1959</i> and last saw him alive on <i>May 4, 1959</i> Death occurred at <i>6:50 P.M.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>William J. Treitas, D.O.</i>		22b. ADDRESS <i>Lutesville Mo</i>	22c. DATE SIGNED <i>5-9-59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>May 8, 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Baker Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Lutesville Mo.</i>
24. FUNERAL DIRECTOR ADDRESS <i>Baker Funeral Home, Lutesville Mo</i>		25. DATE RECD. BY LOCAL REG. <i>5-12-1959</i>	26. REGISTRAR'S SIGNATURE <i>Drene Kasten</i>

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

3961 C B XVT

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 J. E. Graham

Licensed Embalmer No. 4010

P. O. Address Lutesville, W. Va.

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.