

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030225

FILED VS AUG 27 1959

2 7556

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Length of stay in 1b <i>5 days</i>	c. CITY OR TOWN <i>St. Louis</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>Frisco Employees</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>3848 Shaw</i>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>Albert</i> Last <i>Baker</i>			4. DATE OF DEATH Month <i>Aug.</i> Day <i>13</i> Year <i>1959</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</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>Mar 8, 1888</i>	9. AGE (last birthday) <i>72 yr</i>	IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Flagman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Railroad</i>	11. BIRTHPLACE (City and state or country) <i>New Madrid Co, Mo.</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>		
13a. FATHER'S NAME <i>Peter</i>		13b. MOTHER'S MAIDEN NAME <i>Evelyn Daugherty</i>		14. NAME OF HUSBAND OR WIFE <i>Carrie Brown Baker</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NE</i>		16. SOCIAL SECURITY NO. <i>Yes (Unk)</i>	17. INFORMANT <i>Wife</i>	Address <i>Some-3848 Shaw</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>Arteriosclerotic Cardiovascular Dis with Heart Failure</i>					INTERVAL BETWEEN ONSET AND DEATH <i>July 15, 1959</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <i>Nephrosclerosis 442x</i>		DUE TO (c) <i>7-15-59</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <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>July 8, 59</i> to <i>Aug 13, 59</i> and last saw <sup>her</sup> him alive on <i>Aug 13, 1959</i> Death occurred at <i>12:35 A</i> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <i>Norman Miller M.D.</i>			22b. ADDRESS <i>2960 Laclede Ave</i>		22c. DATE SIGNED <i>8-13-59</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>8-14-59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mounds Park</i>		23d. LOCATION (City, town, or county) <i>Lilbourn, Mo.</i>	(State)	
24. FUNERAL DIRECTOR <i>McLaughlin Funeral Home</i>		ADDRESS <i>2301 Lafayette, St. Louis, Mo.</i>	25. DATE RECD. BY LOCAL REG. <i>AUG 14 '59</i>	26. REGISTRAR'S SIGNATURE <i>Neal Smith, M.D.</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *F. G. Jarvis*

Licensed Embalmer No. 338

P. O. Address St. Louis

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.