

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-022143
STATE FILE NUMBER

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 83

FILED JUN 28 1961

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Pike</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pike</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Louisiana</u> | | Length of stay in 1b <u>2 months</u> | c. CITY OR TOWN <u>Louisiana</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Pike County Hospital</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>516 Maryland St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>Ellis</u> Last <u>Baker</u> | | | 4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>1961</u> |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>11/10/76</u> |
| 9. AGE (last birthday) <u>84</u> | | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home Making</u> | 11. BIRTHPLACE (City and state or country) <u>Lynchburg, Virginia</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u> | | 13a. FATHER'S NAME <u>Robert McDaniel Smith</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Emma Knight</u> | | 14. NAME OF HUSBAND OR WIFE <u>John M. Baker</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | 17. INFORMANT <u>Emma Sue Baker</u> Address <u>Louisiana, Mo.</u> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pyelonephritis</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic hypertensive cardiovascular renal disease. Auricular fibrillation. Cardiac enlargement. Functional Capacity III.</u> | | | <u>5 wks</u> |
| DUE TO (c) <u>Pulmonary Congestion</u> | | | <u>3 wks</u> |
| 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 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 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 <u>1957</u> to <u>6/25/61</u> and last saw her ^{her} alive on <u>6/24/61</u> Death occurred at <u>1:50 A</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Chas. H. Swellen</u> | | 22b. ADDRESS <u>M.D., 122 S. 3rd., Louisiana, Mo.</u> | 22c. DATE SIGNED <u>6/26/61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>6/27/61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Riverview</u> | 23d. LOCATION (City, town, or county) (State) <u>Louisiana Missouri</u> |
| 24. FUNERAL DIRECTOR <u>Sterne Funeral Home, Louisiana, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>June 26-61</u> | 26. REGISTRAR'S SIGNATURE <u>Bernice Collier</u> |

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

JUL 21 1961

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. B. Stone

Licensed Embalmer No. 4039

P. O. Address Louisiana

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.