

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=61-040666

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. \_\_\_\_\_ Registrar's No. 1091

FILED NOV 20 1961

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>S. Campbell township</u>		c. CITY OR TOWN <u>Springfield</u>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Springfield Rt. 7</u>		d. STREET ADDRESS <u>Rt. 7 Box 454</u>	

3. NAME OF DECEASED (Type or print) First <u>Anthony "Tony" Darryl</u> Middle <u>Baker</u> Last <u>Baker</u>	4. DATE OF DEATH Month <u>November</u> Day <u>10</u> Year <u>1961</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-23-1956</u>	9. AGE (last birthday) <u>5</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) <u>Greene County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Robert Baker</u>	13b. MOTHER'S MAIDEN NAME <u>Lomanda Baker</u>	14. NAME OF HUSBAND OR WIFE -----
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Robert Baker, Springfield, Missouri</u>	Address
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Medullary Paralysis</u>		
DUE TO (b) <u>Increased intracranial pressure</u>		
DUE TO (c) <u>Hydrocephalus and Meningocele</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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month _____ Day _____ Year _____
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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
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21. I attended the deceased from June 23 1956 to Nov 10 1961 and last saw her alive on Nov 9 1961.  
Death occurred at 5:30 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>D. J. Youll, D.O.</u> (Degree or title)	22b. ADDRESS <u>Springfield Mo</u>	22c. DATE SIGNED <u>II-II-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-12-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arnold Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>near Mt. View, Missouri</u>
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24. FUNERAL DIRECTOR <u>Rex Rainey, Springfield, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>11-15-61</u>	26. REGISTRAR'S SIGNATURE <u>Effie G. Melton</u>
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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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

\*\*\*\*\*  
Not Embalmed  
\*\*\*\*\*

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.