

**MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-61-046050**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

XC-163897 SL 27158

Registration District No. \_\_\_\_\_

Primary Registration District No. **1003**

Registrar's No. **11465**

STATE FILE NUMBER

AMENDED

**FILED DEC 18 1961**

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO.</b>		Length of stay in 1b <b>18 DAYS</b>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>INDIANA</b> b. COUNTY <b>POSEY</b>		c. CITY OR TOWN <b>MT. VERNON</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VET ADM HOSPITAL</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>521 WOLFLIN STREET</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>BAKER</b> Last <b>BAKER</b>				4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>8</b> Year <b>1961</b>					
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11-18-96</b>	9. AGE (last birthday) <b>65</b>	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) <b>GENERAL LABORER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (City and state or country) <b>JUNCTION, ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>WILLIAM BAKER</b>			13b. MOTHER'S MAIDEN NAME <b>JOANNA THOMPSON</b>			14. NAME OF HUSBAND OR WIFE <b>JAUNITA BAKER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WWI</b>			16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>JAUNITA BAKER, SEE #2d</b>				
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) <b>CONGESTIVE HEART FAILURE</b>								<b>18 HOURS</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.									
DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE:</b>									
DUE TO (c) <b>AND METASTATIC ADENOCARCINOMA OF THE COLON</b>								<b>2 MONTHS</b>	
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. <b>420-04</b> <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. Attended the deceased from <b>11-20-61</b> to <b>12-8-61</b> and last saw him alive on <b>12-8-61</b>		Death occurred at <b>4:48 a.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Typed name) <b>William J. Tierney, M.D.</b>				22b. ADDRESS <b>VAH, ST. LOUIS, MO.</b>			22c. DATE SIGNED <b>12-8-61</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>12-8-61</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <b>Mt. Vernon, Indiana</b>			
24. FUNERAL DIRECTOR <b>Weisinger-Tygart Funeral Home, Mt. Vernon, Ind.</b>				25. DATE REC'D. BY LOCAL OFF. <b>DEC 8 1961</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>			

**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 *Etienne P. Remblus*

Licensed Embalmer No. 4283

P. O. Address St. Louis, Mo

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.