

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-030705

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2197

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB  
 AMENDED

FILED JUL 25 1963

VS 300	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF	DATE AMENDED
Rev. 4/59		
1 <u>4000</u>		
2 <u>306</u>		
3		
4 <u>0</u>		
5 <u>1</u>		
6		
7 <u>1</u>		
8 <u>1</u>		
<u>9525X</u>		
10		
11		
12 <u>41-0</u>		
13		
<u>41</u>	ITEM NO.	SHOULD READ

1. PLACE OF DEATH a. COUNTY <b>Koch ST. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis Koch</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b <b>455 days</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>Robt. Koch Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>5737 Lotus</b>	
3. NAME OF DECEASED (Type or print) First <b>Daniel</b> Middle Last <b>Baker</b>		4. DATE OF DEATH Month <b>July</b> Day <b>5</b> Year <b>1963</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>N-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>10-13-09</b>
9. AGE (last birthday) <b>53 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Mississippi</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>Wilson Baker</b>	
13b. MOTHER'S MAIDEN NAME <b>Frankie Johnson</b>		14. NAME OF HUSBAND OR WIFE <b>Sarah Baker</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <b>Koch Hosp. record, Koch, Missouri</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cor pulmonale with failure</b> DUE TO (b) <b>Pulmonary fibrosis</b> DUE TO (c) <b>525X</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. <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 <b>10:15</b> a.m. p.m. Month, Day, Year <b>4-6-62</b>		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 <b>4-6-62</b> to <b>7-5-63</b> and last saw <b>him</b> alive on <b>7-5-63</b> Death occurred at <b>10:15</b> P.m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <b>Bernard Swanson, M.D.</b>	
22b. ADDRESS <b>Robt. Koch Hosp. Koch, Mo.</b>		22c. DATE SIGNED <b>7-8-63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>7-10-1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Forest City</b>	23d. LOCATION (City, town, or county) (State) <b>Forest City, Arkansas</b>
24. FUNERAL DIRECTOR ADDRESS <b>Ellis Funeral Home-2820 Stoddard Street</b>	25. DATE RECD. BY LOCAL REG. <b>7-9-63</b>	26. REGISTRAR'S SIGNATURE <b>John B. Murphy, 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

*Arthur P. [Signature]*

Licensed Embalmer No. 4198

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.