

MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-61-028395

AMENDED

Registration District No.

042

Primary Registration District No.

1000

830

STATE FILE NUMBER

FILED AUG 21 1961

| | | | |
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| 1. PLACE OF DEATH a. COUNTY BUCHANAN | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE KANSAS b. COUNTY DONIPHAN | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. JOSEPH | | c. CITY OR TOWN ELWOOD | |
| Length of stay in lb 5 DAYS | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOSEPH'S HOSPITAL | | d. STREET ADDRESS (If outside, give location) 505 CONNETT COUT. | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First NELLIE Middle - Last BAKER | | 4. DATE OF DEATH Month AUGUST Day 15 Year 1961 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH JAN. 14, 1906 |
| 9. AGE (last birthday) 55 | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | |
| 11. BIRTHPLACE (City and state or country) FORREST CITY, MO. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME EDWARD MAY | | 13b. MOTHER'S MAIDEN NAME HATTIE ALBERSON | |
| 14. NAME OF HUSBAND OR WIFE MAX BAKER | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. 500-14-7237 | | 17. INFORMANT MAX BAKER | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer Spine & Kidneys Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 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 | | INTERVAL BETWEEN ONSET AND DEATH 1 year | |
| 19. WAS AUTOPSY PERFORMED? YES <input 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 Jan. 12/1961 to Aug. 15/1961 and last saw her alive on Aug. 13/1961 Death occurred at 4:45 P.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE J. G. Swails M.D. (Degree or title) | | 22b. ADDRESS Wathena, Kansas | |
| 22c. DATE SIGNED 8-17-61 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | | 23b. DATE AUG. 17, 1961 | |
| 23c. NAME OF CEMETERY OR CREMATORY OREGON CEMETERY | | 23d. LOCATION (City, town, or county) OREGON MISSOURI | |
| 24. FUNERAL DIRECTOR HARMAN FUNERAL HOME | | 25. DATE RECD. BY LOCAL REG. Aug. 17, 1961 | |
| 26. REGISTRAR'S SIGNATURE Mrs. Clark Sandell | | | |

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

J.G. Swails, M.D. MEDICAL CERTIFICATION

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 Charles M. Harmon

Licensed Embalmer No. 4487

P. O. Address Utah Springs, Co.

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.