

FILED NOV 8 1945 STANDARD CERTIFICATE OF DEATH

34205

State File No.

Registration District No. 224

Primary Registration District No. 5796

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Moniteau
(b) City or town rural Walker Camp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
N. East of California 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Moniteau 68
(c) City or town rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JOSEPH BAKER

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced widowed
(b) Name of husband or wife Eva Franken 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug 9 1853
(Month) (Day) (Year)

8. AGE: Years 92 Months 1 Days 26 If less than one day _____ hr. _____ min.

9. Birthplace Moniteau Mo
(City, town, or county) (State or foreign country)

10. Usual occupation retired farmer

11. Industry or business _____

MOTHER FATHER { 12. Name August Baker
13. Birthplace Moniteau Mo
(City, town, or county) (State or foreign country)
14. Maiden name Margaret Weaver
15. Birthplace Cooper Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Henry J. Baker
(b) Address California Mo

17. (a) burial (b) Date thereof 10-6-1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Catholic cemetery

18. (a) Signature of funeral director A. E. Wilson
(b) Address California Mo

19. (a) 10-5-45 (b) H. P. Ropzoy M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 5th
year 1945 hour 2 minute 50 a. M.

21. I hereby certify that I attended the deceased from Oct 4
thru 1945 to Oct 5 1945
that I last saw him alive on Oct 4 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Suba Cranial Duration
Cerebral hemorrhage 4 days

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. P. Burke, Jr. M.D.
Address California Mo Date signed 10-5-45

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

8
0
0

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed

11-2-45

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
..... Registered Apprentice No.
working under my personal supervision.

Signed

A. E. Wilson

Licensed Embalmer No.

2351

P. O. Address

California, 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 this body is not embalmed, fact should be so stated above.