

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 2074BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 225 PRIMARY REG. DIST. NO. 4335 Registrar's No. 12

1. PLACE OF DEATH a. COUNTY <u>MONTEAU</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>COOPER</u>	
b. CITY OR TOWN <u>TIPTON</u>		c. CITY OR TOWN <u>(RURAL) NORTH MONTEAU</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS <u>CALIFORNIA MO</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) <u>HENRY</u> c. (Last) <u>BAKEY</u>			4. DATE OF DEATH <u>Jan 12 1952</u> (Month) (Day) (Year)		
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	
8. DATE OF BIRTH <u>March 20 - 1860</u>		9. AGE (In years last birthday) <u>91</u>		10. IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>MISSOURI</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					

13a. FATHER'S NAME <u>AUGUST BAKET</u>		13b. MOTHER'S MAIDEN NAME <u>MARGARET WEAVER</u>		14. NAME OF HUSBAND OR WIFE <u>DEAD LOUISE BAKET</u>	
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>No</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs GEO. ODNEAL TIPTON</u> ADDRESS <u>Mo</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		DUPLICATE			<u>3 days</u>	
ANTECEDENT CAUSES		DUPLICATE			<u>10 yrs.</u>	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>Hypertension</u>				
		DUE TO (c) <u>Atherosclerosis</u>				
II. OTHER SIGNIFICANT-CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.				

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from April 11, 1949, to Jan 12, 1952, that I last saw the deceased alive on Jan 11, 1952, and that death occurred at 1245A m., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u> (Degree or title)		23b. ADDRESS <u>Tipton, Mo</u>		23c. DATE SIGNED <u>1-12-52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>1-14-1952</u>		24c. NAME OF CEMETERY OR CREMATORY <u>CEDYON CEMETERY</u>	
24d. LOCATION (City, town, or county) (State) <u>MO</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>C. ALBERT HOYNAECK BAIRIE</u>		ADDRESS <u>HOME MO</u>	
DATE REC'D BY LOCAL REG. <u>Jan 12, 1952</u>		REGISTRAR'S SIGNATURE <u>Mrs. Maude Hudson</u> 203			

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED JAN 15 1952

DISTRICT HEALTH OFFICE No. 3

District File Number .....

Date Filed JAN 15 1952 .....

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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 .....  
Student Embalmer

Signed *C. Albert Hornbuck* .....

Licensed Embalmer No. *2714* .....

P. O. Address *Prarie Home 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.