MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

24522
2928

File No. ____
Registered No. ____

1. PLACE OF DEATH
County Jackson Registration-District No. 399
Township Kay Primary Registration District No. 1002
City Kansas City (No. General Hospital St. ____ Ward)

2. FULL NAME James H. Wm Baker
(a) Residence. No. 2606 Park St. 11 Ward. ____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Rose E Baker

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 6 1862

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ____ hrs. or ____ min.
	66	10	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Sta Water Department Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) ____ (STATE OR COUNTRY) MO

PARENTS

10. NAME OF FATHER James Baker
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ____ (STATE OR COUNTRY) Ky
12. MAIDEN NAME OF MOTHER Sarah Smith
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ____ (STATE OR COUNTRY) Ky

14. INFORMANT Rose E Baker
(Address) 2606 Park

15. FILED 7/4 1929 M M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) ~~July~~ 7/2 1929

17. I HEREBY CERTIFY, that I attended deceased from ____, 19____, to ____, 19____
that I last saw h____ alive on ____, 19____, and that death occurred, on the date stated above, at ____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Deputy Coroner
Suicide, carbolic acid a poison

1.30 (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (SECONDARY) ____ (duration) ____ yrs. ____ mos. ____ ds.

18. WHERE WAS DISEASE CONTRACTED ____
IF NOT AT PLACE OF DEATH ____
DID AN OPERATION PRECEDE DEATH? no DATE OF ____
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS? Autopsy

(Signed) Stanley M Hoey, M. D.
7/3 1929 (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Fulton Mo	7/4 1929
20. UNDERTAKER O'Mast	ADDRESS 416 E 15th

N. B.—Every item of information should be carefully supplied: AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MEDICAL RECORD