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

SEP 2 0 1927

Do not use this space.

24626

1. PLACE OF DEATH
County Jasper. Registration District No. 408
Township Primary Registration District No. 3020
City Carthage Mo (No. St. Ward)
File No.
Registered No.

2. FULL NAME Lamyro Carolin Baird.
(a) Residence. No. 15 Miles N. and East of Carthage Mo St., 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 Female
4. COLOR OR RACE White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married.
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wm Baird.
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 10 - 1895
7. AGE 34 YEARS MONTHS DAYS 9 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(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) Jasper Co Mo.

PARENTS
10. NAME OF FATHER H. G. Tiller.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Green Co Mo.
12. MAIDEN NAME OF MOTHER May Marsh
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Bradgan Co Ky.

14. INFORMANT Mrs H. G. Tiller.
(Address) Jasper Mo
15. FILED Aug 20, 1927 S. B. Clinton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 19 1927
17. I HEREBY CERTIFY, That I attended deceased from July 20, 1927, to Aug 18, 1927 that I last saw her alive on Aug 18, 1927, and that death occurred, on the date stated above, at 4 - a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Meningitis
79A
36
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Septicemia
(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? no
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) David Hise, M. D
, 19 (Address) Carthage Mo

*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 Faskin Cemetary
DATE OF BURIAL Aug 21 1927
20. UNDERTAKER Ulmer-Drake
ADDRESS Carthage Mo

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.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jasper — Registration District No. 408 — File No. .....

Township ..... — Primary Registration District No. 3020 — Registered No. .....

City Carthage (No. ....., ... St. ..... Ward)

2. FULL NAME Lamyra Carolin Baird

(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)

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)
F	W	M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 10-1895

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
X	32 X	0	9	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(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)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED Oct 31, 1927 S. B. Clinton
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 19 1927

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:

.....

.....

.....

..... (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? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ....., M. D

, 19 (Address)

*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
Fasken Cemetery	8-21 1927
20. UNDERTAKER	ADDRESS
Ulmer-Drake	

SUPPLEMENTARY

N. . .—F item of informati n should be carefully supplied. AGE should be stated EXACTLY. PHYSIC a state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

[illegible]-5