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0-39
39
21492

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 337 Colorado 2
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether _____)
 In this community 25 yrs.
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Jackson
 (c) City or town Kansas
(If outside city or town limits, write "RURAL")
 (d) Street No. 337 Colorado
(If rural, give location)

3. (a) PRINT FULL NAME Ida Josephine Baird

3. (b) If veteran, name war no 3. (c) Social Security No. no 603

4. Sex Female 5. Color or race Wh 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife David Baird 6. (c) Age of husband or wife if alive 4 years

7. Birth date of deceased Feb 22 1853
(Month) (Day) (Year)

8. AGE: Years 86 Months 5 Days 24
 If less than one day _____ hr. _____ min.

9. Birthplace Waukesha Wis.
(City, town, or county) (State or foreign country)

10. Usual occupation Nurse

11. Industry or business Private Duty

12. Name Samuel A. Seaman

13. Birthplace no record Wis.
(City, town, or county) (State or foreign country)

14. Maiden name Minerava Phillips

15. Birthplace no record Wis.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. June Watson
(b) Address 337 So. Colo. K.C. Mo.

17. (a) Burial (b) Date thereof 8/16/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Park Cem. K.C. Mo.
18. (a) Signature of funeral director James E. Johnson
(b) Address Independence, Mo.

19. (a) Aug. 17, 1940 (b) A. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 16
year 1940 hour 6 minute _____ A. M.

21. I hereby certify that I attended the deceased from July - 1939 to Aug 16 1940
that I last saw or alive on Aug 15 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary insufficiency - 1 yr
arterio-sclerosis
hypertension

Due to _____
Due to _____

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: none
Of operations _____
Of autopsy none

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) (c) Means of injury _____

23. Signature W. W. Martin (M. D. or other) _____
Address 5321 E 24 St Date signed 8-17-40

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

Dr. Martin

5328 1/2 B-24

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 *Raymond N. Martin*

Licensed Embalmer No. *4150*

P. O. Address *Independence*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.