

No. 2
4-13-40
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **30540**

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **7817**

FILED OCT 25 1940

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital #1.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 Days**
(Specify whether
In this community **4 YRS.**
years, months or days)

3. (a) PRINT FULL NAME **Robert Baird**

3. (b) If veteran, name war **NONE** 3. (c) Social Security No. **NONE**

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **WIDOWED**

6. (b) Name of husband or wife **LAURIE BAIRD** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **MAY 12 1866**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	74	4	6	hr. min.

9. Birthplace _____ **INDIANA.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired (Bar tender)** **9**

11. Industry or business _____

12. Name **JOHN S. BAIRD** **9**

13. Birthplace _____ **UNKNOWN**
(City, town, or county) (State or foreign country)

14. Maiden name **SARAN AUG**

15. Birthplace _____ **UNKNOWN**
(City, town, or county) (State or foreign country)

16. (a) Informant **Miss Geraldine Miss**

(b) Address **2543 N. 63rd St. Chicago - Ill.**

17. (a) **Burial** (b) Date thereof **Sept. 20-1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bellefontaine Cemetery**

18. (a) Signature of funeral director **Wm. M. Schumacher**
(b) Address **4834 N. Natural Bridge**

19. (a) **SEP 19 1940** (b) _____
(Date received by registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County.....
(c) City or town **St. Louis** **19**
(If outside city or town limits, write "RURAL")
(d) Street No. **4010 OLIVE ST.**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **September** day **18**,
year **1940** hour **8:40** minute **P.** M.

21. I hereby certify that I attended the deceased from **September 15**, 19**40**, to **September 18**, 19**40**, that I last saw him alive on **September 18**, 19**40**; and that death occurred on the date and hour stated above.

Immediate cause of death **Hyper-tensive Heart Disease**

Due to **Syphilis**

Due to **2/1**

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy _____

Duration

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) (b) Means of injury _____

23. Signature **[Signature]** (M. D. or other) _____
Address **1515 Lafayette Ave.** Date signed **9/19/40**

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.....

John Ketter
Licensed Embalmer No. *3880*

P. O. Address.....

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.