

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **42121**

Registration District No. **163**

Primary Registration District No. **4095**

Registrar's No. **60**

1. PLACE OF DEATH:

(a) County **Cedar**
(b) City or town **El Dorado Springs**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days) **2**

3. (a) PRINT FULL NAME **SIGEL F. BAIRD**

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

4. Sex **MALE** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Anna Baird** 6. (c) Age of husband or wife if alive **65** years
7. Birth date of deceased **Oct 23 - 1861**
(Month) (Day) (Year)

8. AGE: Years **79** Months **1** Days **24** If less than one day _____ hr. _____ min.

9. Birthplace **Bolivar, Mo** (City, town, or county) **Mo** (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business

12. Name **Samuel Baird**
13. Birthplace **Ohio** (City, town, or county) (State or foreign country)
14. Maiden name **Mary Field**
15. Birthplace **Ohio** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Anna Baird**

(b) Address **El Dorado Springs, Mo**
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **12-19-1940**
(Month) (Day) (Year)

(c) Place: burial or cremation **El Dorado Springs, Cem**

18. (a) Signature of funeral director **Wm. J. Stiles**

(b) Address **El Dorado Springs, Mo**
19. (a) **12/19/40** (Date received local registrar) (b) **J. W. Dawson** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Cedar**
(c) City or town **El Dorado Springs, Mo**
(If outside city or town limits, write "RURAL")
(d) Street No. **816 S Grand**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **17**
year **1940** hour **4** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **Dec 15 - 1940**
to **DEC 17 - 1940**
that I last saw him alive on **DEC 15 - 1940**
and that death occurred on the date and hour stated above.

Immediate cause of death **Heart Block** Duration **1 Da**

Due to _____
Due to _____

Other conditions **Hiccough**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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? **1511**

While at work? **1511** (Specify type of place) (e) Means of injury _____

23. Signature **J. W. Dawson** (D. or other) **1**
Address **El Dorado Springs** Date signed **12/19/40**

RECEIVED

District Health Officer No. 7.

District File Number 1-41-71

Date Filed 1-10-41

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 _____

Licensed Embalmer No. _____

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, above space should be left blank.