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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11000

FILED APR 27 1945

Registration District No. 818 Primary Registration District No. 1002 Registrar's No. 3382

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

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5114 Wabada
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 006
(c) City or town St. Louis 176
(If outside city or town limits, write "RURAL")
(d) Street No. 5114 Wabada
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country No 0

3. (a) PRINT FULL NAME Harvey T. Laird
3. (b) If veteran, name war
3. (c) Social Security No. 527-03-2494
4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Flora M. Laird
6. (c) Age of husband or wife if alive 43 years
7. Birth date of deceased Aug (Month) 4 (Day) 1883 (Year)
8. AGE: Years 61 Months 8 Days 10 If less than one day hr. min.
9. Birthplace Mississippi (City, town, or county) (State or foreign country)
10. Usual occupation Telegraph Supervisor
11. Industry or business Armour Packing Co.
FATHER 12. Name Unknown Laird
FATHER 13. Birthplace Unknown (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Talbot
MOTHER 15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. Harvey T. Laird
(b) Address 5114 Wabada
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 17 45 (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla Cem.
18. (a) Signature of funeral director Drehmann-Harral
(b) Address 1905 Union Blvd.
19. (a) APR 17 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day 14 year 1945 hour 7 minute 30 A. M.
21. I hereby certify that I attended the deceased from April 4th 1945, to April 14th 1945 that I last saw him alive on April 14th 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic myocarditis — Duration 4 years
Due to
Due to
Other conditions (Include pregnancy within 3 months of death): none
Major findings: Of operations: none
Of autopsy: no

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) no
(b) Date of occurrence no
(c) Where did injury occur? no (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? no (Specify type of place)
While at work? no (e) Means of injury no
23. Signature J. Bickford (M. D. or other)
Address 425 Natural Bridge Date signed 4/14/45

(Licensed Embalmer's Statement on Reverse Side)

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 Warren A. Carver

Licensed Embalmer No. 3534

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.