

FILED AUG 9 1945

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 270Primary Registration District No. 3053Registrar's No. 70

1. PLACE OF DEATH:

- (a) County Phelps
 (b) City or town Rolla
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution Nova McFarland Memorial Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 50 minutes
 (Specify whether _____)
 In this community Same
 years, months or days)

3. (a) PRINT
FULL NAMENot named Baird3. (b) If veteran,
name war _____3. (c) Social Security
No. _____4. Sex Male05. Color or
race w6. (a) Single, widowed, married,
divorced S. 0

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if
alive _____ years

7. Birth date of deceased

May
(Month)28, 1945
(Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

hr. 50 min.

9. Birthplace

Rolla,
(City, town, or county)Mo.
(State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name

Do not know

13. Birthplace

(City, town, or county)

(State or foreign country)

14. Maiden name

Faye Baird

15. Birthplace

(City, town, or county)

(State or foreign country)

16. (a) Informant

Faye Baird, mother

(b) Address

1 Hobson, Mo.

17. (a) _____

(b) Date thereof

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director

Do not know

(b) Address _____

19. (a)

7-24-45
(Date received local registrar)(b) Mrs. Juanita Harvey
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____
 (c) City or town _____
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 28,
year 1945 hour 2 minute 20 A. M.21. I hereby certify that I attended the deceased from 1:30 a.m.
5-28, 1945 to 5-28, 1945that I last saw him alive on 5-28, 1945
and that death occurred on the date and hour stated above.Immediate cause of death Immature

Duration

Due to

(6-months baby)

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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)

(e) Means of injury _____

23. Signature _____

Address Rolla, Mo.

(M. D. or other) _____

Date signed 7/21/45

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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24663
Registrar's No. 70

Registration District No. 275 Primary Registration District No. 3053

1. PLACE OF DEATH: Phelps Kolla
(a) County.....
(b) City or town.....
(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)

3. (a) PRINT FULL NAME Garid
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex m 5. Color wn 6. (a) Single, widowed, married, divorced s

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

7. Birth date of deceased may 20
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
hr. 50 min. mo

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

10. Usual occupation.....

11. Industry or Business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant nmo

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) Jan. 16, 1946 (b) Mrs. Juanita Ramsey
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits, write "RURAL")
(d) Street No..... (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan Day 18 Year 1945 hour..... minute..... M.
21. I hereby certify that I attended the deceased from..... to..... 19.....
that I last saw him..... alive on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Due to.....
Due to.....
Other conditions..... (include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations.....
Of autopsy.....
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) (e) Means of injury.....

23. Signature..... (M. D. or other)
Address..... Date signed.....

date, though I have sent two letters to the address above
you.

SUPPLEMENTARY

MOTHER FATHER

S-24663