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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

26283

State File No.

FILED AUG 27 1946

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 943

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

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2601 Faraon St. /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 45 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan 11

(c) City or town St Joseph /
(If outside city or town limits, write "RURAL")

(d) Street No. 2601 Faraon 7
(If rural, give location)

(e) Citizen of foreign country? No 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Belle F. Baird

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female /

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed /

6. (b) Name of husband or wife James W.

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

7. Birth date of deceased May (Month) 18 (Day) 1855 (Year)

8. AGE: Years 91 Months 3 Days 0 If less than one day ..... hr. ..... min.

9. Birthplace Pickwick Co. (City, town, or county) Ohio / (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name ? Schreckengaust
13. Birthplace Not Known 9 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Susan Resler
15. Birthplace - (City, town, or county) Penn. / (State or foreign country)

16. (a) Informant Mrs. G.S. Fulton
(b) Address St Joseph, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-20-46 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Auburn Cemetery

18. (a) Signature of funeral director Fleeman & Son Inc.
(b) Address St Joseph, Mo.

19. (a) Aug. 23, 1946 (Date received local registrar) (b) [signature] (Registrar's signature) By N.N.H.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 18
year 1946 hour 4 minute 40 A M.

21. I hereby certify that I attended the deceased from August 1st 1946 to Aug 18 1946
that I last saw her alive on August 17 1946
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral apoplexy	2 Wks
Due to Hypertension and age.	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

830

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?
(Specify type of place)

While at work? (e) Means of injury 0

23. Signature Leroi Beck M.D. (M. D. or other)

Address King Hill Bldg St Joseph Mo Date signed 8/19/46

(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 Robert R Yoper

Licensed Embalmer No. 3308

P. O. Address St Joseph, Mo.

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.