

U. S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X38671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 34034  
Registrar's No. 83

Registration District No. 177 Primary Registration District No. 3003

10-24-46-46: J.  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
(a) County Lawrence  
(b) City or town Monett  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 9 years years, months or days) (Specify whether

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Lawrence  
(c) City or town Monett  
(If outside city or town limits, write "RURAL")  
(d) Street No. 911 9th St.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Ruth Cynthia Baird  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. no

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Oct. day 10  
year 1946 hour 4 minute 30 A.M.  
21. I hereby certify that I attended the deceased from Sept 25  
1946 to Oct 10, 1946  
that I last saw her alive on Oct 9, 1946  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Hugh A. Baird 6. (c) Age of husband or wife if alive 43 years  
7. Birth date of deceased: July 13 1907  
(Month) (Day) (Year)

Immediate cause of death Bronchial pneumonia 4 days  
Duration \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
39 2 27 hr. min.

Major findings: 107  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

9. Birthplace Rogers Arkansas  
(City, town, or county) (State or foreign country)  
10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_  
12. Name John Rhoades  
13. Birthplace Pa.  
(City, town, or county) (State or foreign country)  
14. Maiden name Mattie Parks  
15. Birthplace Ill.  
(City, town, or county) (State or foreign country)

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?

16. (a) Informant Hugh A. Baird  
(b) Address 911-9th Monett Mo.  
17. (a) Burial (b) Date thereof Oct. 10, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Rogers Arkansas  
18. (a) Signature of funeral director Blankenship  
(b) Address Monett Mo.  
19. (a) 10-11-46 (b) W. M. West  
(Data received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature W. M. West (M. D. or other) MD  
Address Monett Mo. Date signed 10-11-46

RECEIVED

District Health Officer No. 6,

District File Number 1046-1076

Date Filed OCT 23 1946

OCT 28 1946

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 L. H. Blankenship

Licensed Embalmer No. 2397

P. O. Address Monett, 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.