No. 2
-1/47
-17-

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

27376

State File No. .....

FILED AUG 26 1947

Registration District No. 147

Primary Registration District No. 1802

Registrar's No. 3507

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: St. Mary's Hosp. 0
(If not in hospital or institution, write street, number or location)

(d) Length of stay: In hospital or institution 16½ hrs. (Specify whether
In this community 16½ hrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson 48

(c) City or town Kansas City. 3
(If outside city or town limits, write "RURAL")

(d) Street No. 4119 Olive St. 8
(If rural, give location)

(e) Citizen of foreign country? no. (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Infant Beaird (Patricia Ramsey Beaird)

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 Child 0

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

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

7. Birth date of deceased August 13, 1947
(Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day 16½ hr. ..... min.

9. Birthplace Kansas City, Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation ----- infant

11. Industry or business .....

FATHER
12. Name Raymond E. Beaird
13. Birthplace St. Joseph, Mo. 0
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Sylvia M. Thompson
15. Birthplace England 4
(City, town, or county) (State or foreign country)

16. (a) Informant Raymond E. Beaird
(b) Address 4119 Olive St.

17. (a) Burial (b) Date thereof Aug. 15, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director Thos. E. Quirk
(b) Address 4316 Troost Ave.

19. (a) 8-15-47 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 14th
year 1947 hour 10.43 A.M. minute ..... M.

21. I hereby certify that I attended the deceased from 8/13/47
....., 19..., to 8/14/47, 19...;
that I last saw her alive on 8/14/47, 19...;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Prematurity & Atelectasis	18 hr
Due to	
Due to Placenta Praevia in mother	72 hr
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 0 159	
Of autopsy	

PHYSICIAN — Underline the cause of 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? ..... Means of injury .....

23. Signature Harold Glaney (M. D. or other)

Address 227 Plaza Med Bldg Date signed 8/14/47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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

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. 3375

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.