S. No. 300
10.48

FILED MAR 8 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6874

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3063 Registrar's No. 382

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Clayton
c. LENGTH OF STAY (in this place) 1 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Louis County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY St. Louis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ferguson
d. STREET ADDRESS (If rural, give location) 6171 Emerald

3. NAME OF DECEASED (Type or Print)
a. (First) Eli
b. (Middle) D.
c. (Last) Baird

4. DATE OF DEATH (Month) 2 (Day) 12 (Year) 1949

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) wid
8. DATE OF BIRTH 2-22-66
9. AGE (In years last birthday) 82 — IF UNDER 1 YEAR Months 11 Days 21 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (State or foreign country) Bullet County, Kentucky
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Tom Baird
13b. MOTHER'S MAIDEN NAME Kate Michael
14. NAME OF HUSBAND OR WIFE Martha

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME ADDRESS St. Louis County Hospital Records

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Cardiovascular Disease

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriolar Nephrosclerosis

DUE TO (c) 443X

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 11, 1949, *to* Feb. 12, 1949, *that I last saw the deceased alive on* Feb. 12, 1949, *and that death occurred at* 11:25 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE R. R. Cohle (Degree or title) MD.
23b. ADDRESS 601 So. Brentwood, Clayton (5)
23c. DATE SIGNED 2-14-49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 2-13-49
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) Caruthersville (State) Mo

DATE REC'D BY LOCAL REG. 2-13-49
REGISTRAR'S SIGNATURE Thurid C. Lemmingen MD
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland Mortuary Service 4104 Manchester Ave.

(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 ..... Student Embalmer No. ..... working under my personal supervision.

Signed Ronald O Yahnke

Signed ..... Student Embalmer

Licensed Embalmer No. 3917

P. O. Address St Louis 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.