

FILED JUL 5 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 20735

5374

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No.	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY				a. STATE Missouri		b. COUNTY Pemiscot	
b. CITY (If outside corporate limits, write RURAL and give town)		c. LENGTH OF STAY (in this place) (If outside corporate limits, write RURAL and give township)		c. CITY (If outside corporate limits, write RURAL and give township)			
St. Louis, Missouri		76 days		Holland		10	
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS			
Barnes Hospital,				M.R.			
3. NAME OF DECEASED			4. DATE OF DEATH				
a. (First) Robert			b. (Middle) Franklin			c. (Last) Baird	
(Type or Print)			4. DATE OF DEATH			June 17, 1949	
5. SEX		6. COLOR OR RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH	
Male		White		Never Married		March 23, 1933	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)	
Student				16		Caruthersville, Mo. 0	
12. CITIZEN OF WHAT COUNTRY?			13a. FATHER'S NAME				
U.S.			Paul Baird				
			13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE		
			Jewell Somford		None		
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		
No			None		Paul Baird, Caruthersville, Mo.		
18. CAUSE OF DEATH		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)					6 hrs.
		Pulmonary edema					
		ANTECEDENT CAUSES					
		Subacute bacterial endocarditis					15 wks.
		Bicuspid aortic valve congenital					
		Aneurysm Sinus of valsalva congenital					
		II. OTHER SIGNIFICANT CONDITIONS					
		Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY?
		Exploratory thoracotomy					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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)	
				151st		Missouri	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
				75 ft.			
22. I hereby certify that I attended the deceased from April 2, 1949, to June 17, 1949, that I last saw the deceased alive on June 17, 1949, and that death occurred at 10:45 P.M., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title)				23b. ADDRESS		23c. DATE SIGNED	
F.R. Bradley				Barnes Hospital,		6/18/49	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)	
Removal		6-18-49		Mt. Zion		Steele, Mo.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		
JUN 21 1949		J.B. Baseler			Albert H. Hoppe, 4700 Washington Blvd		

(Licensed Embalmer's Statement on Reverse Side)

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

6700

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**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.

Student .....  
Student Embalmer

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.