

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

BIRTH NO.		REG. DIST. NO. 42	PRIMARY REG. DIST. NO. 1000	Registrar's No. 1045
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).		
a. COUNTY Buchanan		a. STATE MO		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rt 2 south mo		b. COUNTY Buchanan		
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) Rt 2 south mo 0117		
d. FULL NAME OF HOSPITAL OR INSTITUTION Idle Hour Nursing Home		d. STREET ADDRESS (If rural, give location) 218 S-10		
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH		(Month) (Day) (Year)
a. (First) Maretha		b. (Middle) E		c. (Last) Baird
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH Oct 12 1872		9. AGE (In years last birthday) 78		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house instructor		10b. KIND OF BUSINESS OR INDUSTRY music		11. BIRTHPLACE (State or foreign country) Lavo Co mo 0
12. CITIZEN OF WHAT COUNTRY? Amerioa		13a. FATHER'S NAME Mr Wright		13b. MOTHER'S MAIDEN NAME not sure
14. NAME OF HUSBAND OR WIFE John W Baird		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —
17. INFORMANT'S SIGNATURE OR NAME Records		ADDRESS Idle Hour Nursing Home • 218 S. 10th		
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) Cerebral haemorrhage		2 years
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES		
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
		DUE TO (b) Bronchitis, fractured hip		
		DUE TO (c) arterio sclerosis		
		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? YES <input type="checkbox"/> NO <input checked="" 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) E 9030-20
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) ✓		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? ✓
22. I hereby certify that I attended the deceased from Dec - 1950 , to Oct 6, 1951 , that I last saw the deceased alive on Oct 5, 1951 , and that death occurred at 8:00 m., from the causes and on the date stated above.				
23a. SIGNATURE Collis Pounding M.P.		23b. ADDRESS St Paul street Bldg Oct 6-51		23c. DATE SIGNED Oct 6-51
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial A		24b. DATE 10/8/51		24c. NAME OF CEMETERY OR CREMATORY Altamont Cemetery
24d. LOCATION (City, town, or county) (State) Altamont, Missouri		25. FUNERAL DIRECTOR'S SIGNATURE Pattonsburg, Mo.		
DATE REC'D BY LOCAL REG. October 11, 1951		REGISTRAR'S SIGNATURE Carl C. Casper		446

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

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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 *Louis Gust*

Licensed Embalmer No. *4096*

P. O. Address *Pottsville, Pa.*

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.