

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 15 1951

State File No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10814**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Incarinate Word Hosp		d. STREET ADDRESS (If rural, give location) 3 709 1/2 Mardel Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) Robert b. (Middle) c. (Last) Baird			4. DATE OF DEATH (Month) (Day) (Year) Dec. 5 1951		
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 15, 1875	9. AGE (In years last birthday) Months Days Hours Min. 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Mark Andy Inc.		11. BIRTHPLACE (State or foreign country) Sparta, Ill.	

13a. FATHER'S NAME Daniel Baird	13b. MOTHER'S MAIDEN NAME Unk'n	14. NAME OF HUSBAND OR WIFE Lillie C. Baird
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Lillie C. Baird	ADDRESS 709 1/2 Mardel Ave.
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 4 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary infarction		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
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"/>
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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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4201

22. I hereby certify that I attended the deceased from **Dec 5**, 19**51**, to **Dec**, 19**51**, that I last saw the deceased alive on **Dec 4**, 19**51**, and that death occurred at **4:00A** m., from the causes and on the date stated above.

23a. SIGNATURE W B Kappesser MD	(Degree or title)	23b. ADDRESS 328 1/2 Marlowe	23c. DATE SIGNED 12-3-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Dec. 8, 1951	24c. NAME OF CEMETERY, OR CREMATORY Lake Charles Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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DATE REC'D BY LOCAL REG. DEC 6 1951	REGISTRAR'S SIGNATURE Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE C. HOFFMEISTER	ADDRESS COLONIAL MORTUARY 646 1/2 Chippewa St., St. Louis, Mo.
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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.

Student
Student Embalmer

Signed *Linus C. Hoffmeister*

Licensed Embalmer No. *3871*

P. O. Address *7814 S. Broadway*

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.