

LEJ JUN 2 1952

THE DIVISION OF HEALTH - MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15738

BIRTH NO. _____ REG. DIST. NO. 46 PRIMARY REG. DIST. NO. 4063 Registrar's No. 20

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

1. PLACE OF DEATH a. COUNTY Caldwell		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Caldwell	
b. CITY (If outside corporate limits, write RURAL and give township) Hamilton		c. CITY (If outside corporate limits, write RURAL and give township) Hamilton 0130	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) Calif. St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) Lessing (Middle) Marguard (Last) Baird			4. DATE OF DEATH (Month) (Day) (Year) 5-20-1952		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 9-10-1875	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months 8 Days 10	IF UNDER 1 MIN. Hours
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Plumber	10b. KIND OF BUSINESS OR INDUSTRY Coshocton Co Ohio	11. BIRTHPLACE (State or foreign country) Coshocton Co Ohio	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME James W. Baird	13b. MOTHER'S MAIDEN NAME Sophia Glass	14. NAME OF HUSBAND OR WIFE Nellie Baird
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 486-09-4104	17. INFORMANT'S SIGNATURE OR NAME Mrs Nellie Baird	ADDRESS Hamilton Mo
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 days 14 weeks.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia.		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Hemorrhage 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 33 IX	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)
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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?
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22. I hereby certify that I attended the deceased from Feb 12, 1952, to May 20, 1952; that I last saw the deceased alive on May 19, 1952, and that death occurred at 12:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE Herbert P. Borch M.D.	23b. ADDRESS Hamilton Mo	23c. DATE SIGNED 5/21/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5/22/52	24c. NAME OF CEMETERY OR CREMATORY Highland	24d. LOCATION (City, town or county) (State) Hamilton Mo
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DATE REC'D BY LOCAL REG May 26-52	REGISTRAR'S SIGNATURE Gladys Jones Bram	25. FUNERAL DIRECTOR'S SIGNATURE Funeral Home Hamilton	ADDRESS Hamilton Mo
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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 _____

working under my personal supervision.

Signed.....
Student Embalmer

Student Embalmer No.....

Signed

R. Lester Bram

Licensed Embalmer No. *4472*

P. O. Address *Hamilton 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.