

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **7161**FILED MAR 2 1954
BIRTH NO. REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **547** Registrar's No. **429**

1. PLACE OF DEATH a. COUNTY St. Louis,		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 Richmond Heights		c. LENGTH OF STAY (in this place) 2 Days	c. CITY OR TOWN St. Louis,
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Mary's Hospital.		e. STREET ADDRESS (If rural, give location) 1920a Geyer Ave.	
3. NAME OF DECEASED (Type or Print) a. (First) Ruth b. (Middle) c. (Last) Baird		4. DATE OF DEATH (Month) (Day) (Year) Feb. 13, 1954.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 13, 1899
9. AGE (In years last birthday) 55		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (City and State or Foreign Country) Hudsonville, Illinois.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME John Colliflower		13b. MOTHER'S MAIDEN NAME E. Johnson	14. NAME OF HUSBAND OR WIFE Roy Baird.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. Nil.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Leroy Baird 1920a Geyer Ave.
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia 48 hrs. ANTECEDENT CAUSES DUE TO (b) Metastatic carcinoma DUE TO (c) Carcinoma of cervix 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)
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?
22. I hereby certify that I attended the deceased from 2/12, 1954 , to 2/13, 1954 , that I last saw the deceased alive on 2/13, 1954 , and that death occurred at 11:20 PM m., from the causes and on the date stated above.			
23a. SIGNATURE (Deceased or title) Herbert R. Dombrowski		23b. ADDRESS 6376 Clayton Rd. (17)	23c. DATE SIGNED 2-15-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 2-16-54	24c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery	24d. LOCATION (City, town, or county) (State) Charleston, Missouri.
DATE REC'D BY LOCAL REG. 2-16-54	REGISTRAR'S SIGNATURE Herbert R. Dombrowski	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 Washington.	

(Licensed Embalmer's Statement on Reverse Side)

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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.....
Signature of Student Embalmer

Signed *John J. Harris*
Licensed Embalmer No. 410
P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.