No. 300
10.48

FILED JUN 15 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17703

State File No.

BIRTH NO. REG. DIST. NO. 358 PRIMARY REG. DIST. NO. 4524 Registrar's No. 8

1080
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1. PLACE OF DEATH
a. COUNTY: Vernon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Walker
c. LENGTH OF STAY (In this place): 1yr 8 mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Missouri
b. COUNTY: Vernon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Walker
d. STREET ADDRESS (If rural, give location):

1080
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3. NAME OF DECEASED (Type or Print)
a. (First): Flossie
b. (Middle): L.
c. (Last): Baird

4. DATE OF DEATH (Month) (Day) (Year): June 10, 1954

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: April 25, 1884

9. AGE (In years last birthday): 70
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and State or Foreign Country): Ill.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Charles H/ Peters

13b. MOTHER'S MAIDEN NAME: Elizabeth

14. NAME OF HUSBAND OR WIFE: Orren Baird

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT'S SIGNATURE OR NAME: Orren Baird
ADDRESS: Walker, Mo/

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, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cancer of large intestines — INTERVAL BETWEEN ONSET AND DEATH: ?

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. Hydrocephalus — several years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: 153 X
20. AUTOPSY? YES ☐ NO ☒

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) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 7/10, 1953, *to* 4/10, 1954, *that I last saw the deceased alive on* 5/29, 1954, *and that death occurred at* 2 a m., *from the causes and on the date stated above.*

23a. SIGNATURE: R. C. Morris (Degree or title): M.D.
23b. ADDRESS: Nevada, Mo.
23c. DATE SIGNED: 6/11/54

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 6-11-54
24c. NAME OF CEMETERY OR CREMATORY: Wichita Cemetery
24d. LOCATION (City, town, or county) (State): Wichita, Ka.

DATE REC'D BY LOCAL REG.: 6-11-54
REGISTRAR'S SIGNATURE: Blis B. Daily 463
FUNERAL DIRECTOR'S SIGNATURE: Eschinger Funeral Home
ADDRESS: Nevada, Mo
(Licensed Embalmer's Statement on Reverse Side)

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

SEP 15 1952

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 Percy F. Melster

Licensed Embalmer No. 4805

P. O. Address Nevada, 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.