

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38445

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>314</u>		PRIMARY REG. DIST. NO. <u>6064</u>		Registrar's No. <u>60</u>		
1. PLACE OF DEATH a. COUNTY <u>St. Clair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Clair</u>				
b. CITY (If outside corporate limits, write RURAL and give township) <u>Osceola</u>		c. LENGTH OF STAY (In this place) <u>20 years</u>		c. CITY OR TOWN <u>Collins</u>		d. Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Waite's Rest Home</u>				e. STREET ADDRESS (If rural, give location) <u>093<sup>rd</sup></u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Charlie</u> b. (Middle) <u>--</u> c. (Last) <u>Baird</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov; 14, 1954</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>	8. DATE OF BIRTH <u>12-12-1870</u>		9. AGE (In years last birthday) <u>83</u>	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) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Common</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Ray County Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>Watson Baird</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>County Welfare Office, Osceola Mo.</u>				
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>hemorrhage of stomach</u>  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. <u>Chronic nephritis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 de</u>  <u>years</u>		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) m.		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 <u>6</u> , 1954, to <u>11-14</u> , 1954, that I last saw the deceased alive on <u>11-13</u> , 1954, and that death occurred at <u>8 A</u> m., from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>Ruth Seewer MD</u>				23b. ADDRESS <u>Osceola Mo</u>		23c. DATE SIGNED <u>11-15-54</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>11-16-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Osceola</u>		24d. LOCATION (City, town, or county) (State) <u>Osceola Missouri</u>			
DATE REC'D BY LOCAL REG. <u>11-18-54</u>		REGISTRAR'S SIGNATURE <u>Ruth Seewer</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Goodrich Home, Osceola Mo</u>				

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.....  
Signature of Student Embalmer

Signed *F. B. Harrison*.....

Licensed Embalmer No. *303*.....

P. O. Address *Osceola*.....

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.