

FILED MAY 4 1942

Registration District No. 49320

Primary Registration District No. 55864256

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Johnson
 (b) City or town Leeeton, Tenn
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)
 In this community 5 yrs
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Johnson
 (c) City or town Leeeton - 51
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Robert Henry Baird

3. (b) If veteran, name war None 3. (c) Social Security No. 702-10-2330

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Amanda M. Baird 6. (c) Age of husband or wife if alive 68 years
 7. Birth date of deceased Feb. 16 1978
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
64 2 6 _____ hr. _____ min.

9. Birthplace California Mo - U
(City, town, or county) (State or foreign country)

10. Usual occupation Section Foreman

11. Industry or business M. K. T.

MOTHER FATHER
 { 12. Name James W. Baird
 { 13. Birthplace Tenn.
(City, town, or county) (State or foreign country)
 { 14. Maiden name Ophele E. Wood
 { 15. Birthplace Mo - U
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Amanda M. Baird
 (b) Address Leeeton, Mo
 17. (a) Burial (b) Date thereof 4-24-42
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Windsor, Mo

18. (a) Signature of funeral director R. A. Branninger
 (b) Address Leeeton, Mo.

19. (a) 4-22-1942 (b) R. A. Branninger
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22
 year 1942 hour 6:45 minute P.M.

21. I hereby certify that I attended the deceased from April 20,
1942 to April 22, 1942
 that I last saw him alive on April 22, 1942
 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____
 Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____
(Specify type of place) (e) Means of injury

23. Signature R. A. Branninger (M. D. or other) Dr.
 Address Leeeton, Mo. Date signed 4-22-42

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

700

P

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 MR

....., Registered Apprentice No.
working under my personal supervision.

Signed RA Brummer

Licensed Embalmer No. 3377

P. O. Address Leeton, 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14692

Registration District No. 420

Primary Registration District No. 4256

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Johnson
(b) City or town Leeton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 5 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Johnson
(c) City or town Leeton
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Robert B. Baird
3. (b) If veteran, name war _____ 3. (c) Social Security No. 702-10-2330

20. DATE OF DEATH: Month Apr Day 23 Year 1942 hour 3 minute 45 P.M.
21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above.
Immediate cause of death Pneumonia
bronchial pneumonia

MEDICAL CERTIFICATION

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb-16-1878
(Month) (Day) (Year)

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy _____

8. AGE: Years 64 Months 2 Days 7 If less than one day _____ min.

9. Birthplace (City, town, or county) _____ (State or foreign country) _____

10. Usual occupation _____

11. Industry of business _____

12. Name _____

13. Birthplace (City, town, or county) _____ (State or foreign country) _____

14. Maiden name _____

15. Birthplace (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place) _____
By Means of injury _____
23. Signature Dr. Nestan (M. D. or other) DO
Address Leeton, Mo. Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

