

No. 2
-12-45
5-17-39
1 X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. **42103**
Registrar's No. **11260**

FILED JAN 7 1947 318
Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution:
Barnes Hospital
(d) Length of stay: In hospital or institution 69 days
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County Madison
(c) City or town Edwardsville
(d) Street No. 420 E. Vandalia St.
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CLARENCE W. Baird
3. (b) If veteran, name war Nil
3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____
7. Birth date of deceased August 22 1885
(Month) (Day) (Year)

8. AGE: Years 61 Months 4 Days 5
If less than one day _____ hr. _____ min.

9. Birthplace Madison County Illinois
(City, town, or county) (State or foreign country)
10. Usual occupation Retired Dentist

11. Industry or business _____
12. Name Robert George Baird
13. Birthplace Madison County Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Anna Kinder
15. Birthplace Madison County Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Frank Tunnell
(b) Address Edwardsville, Ill.
17. (a) Removal (b) Date thereof 12-28-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Edwardsville, Ill.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.
19. (a) DEC 30 1946 (b) J. F. Bredeck
(Date received local report) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 27
year 1946 hour 10 minute 45 A.M.
21. I hereby certify that I attended the deceased from
October 19 1946 to Dec. 27 1946
that I last saw him alive on Dec. 27 1946
and that death occurred on the date and hour stated above.
Immediate cause of death Cardiac decompensation

Due to arteriosclerotic heart disease
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy as above

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 FR Bradley M. D. or other _____
Address Barnes Hospital Date signed _____

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

MOTHER FATHER

99
N.B.
6
2

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

11260

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

Signed Henry M. Brammer
Licensed Embalmer No. 4200
P. O. Address.....

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.