

No. 2
12-45
-17-39
X47070

FILED MAY 20 1947

Registration District No. 122

Primary Registration District No. 4201

Registrar's No. 18

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

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Republic
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Republic Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene ³⁹

(c) City or town Republic ⁰
(If outside city or town limits, write "RURAL") ⁰

(d) Street No. _____ (If rural, give location) ⁰

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME William Nelson Baird

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 7
year 1947 hour 11 minute 40 P. M.

21. I hereby certify that I attended the deceased from
May 4, 1947 to May 7, 1947;
that I last saw him alive on May 7, 1947;
and that death occurred on the date and hour stated above.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lela Baird

6. (c) Age of husband or wife if alive 8 years 59

7. Birth date of deceased Jul 9 1859
(Month) (Day) (Year)

Immediate cause of death Cardiac Thrombosis

Due to _____

Due to _____

8. AGE:

Years	Months	Days	If less than one day
<u>88</u>	<u>2</u>	<u>28</u>	hr. _____ min. _____

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

Major findings:
Of operations _____

Of autopsy _____

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

10. Usual occupation Retired Harness Maker

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

11. Industry or business Harness Making

12. Name Peter Baird

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

14. Maiden name Unknown

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

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? _____

16. (a) Informant Lela Baird

(b) Address Republic Mo.

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof 5-11-1947
(Month) (Day) (Year)

(c) Place: burial or cremation Evergreen Cem. Republic Mo.

23. Signature R. B. ... (If D. or other means of injury) _____

While at work? _____

Address Republic, Missouri Date signed 5/10/47

18. (a) Signature of funeral director W. Klingner & Co.

(b) Address Springfield Mo.

19. (a) May 11 1947 (Date received local registrar)

(b) Florence ... (Registrar's signature) 122

RECEIVED

Greene County Health Office

County File Number 47-5-57

Date Filed 5-19-47

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 Ogle Stone Jr.

Licensed Embalmer No. 4176

P. O. Address Springfield

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.