

33835

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

FILED OCT 24 1956

 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1262

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Jackson</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		a. STATE <u>Kansas</u>		b. COUNTY <u>Johnson</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Luke's</u>		Length of stay in 1b <u>1 day</u>		c. CITY OR TOWN <u>Roeland Park</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
First <u>JAMES</u>		Middle <u>S.</u>		Last <u>BAIRD</u>		Month <u>10</u> Day <u>6</u> Year <u>56</u>	
5. SEX <u>Ma</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-23-1883</u>		9. AGE (In years last birthday) <u>72</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>Ret Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hardware</u>		11. BIRTHPLACE (City and state or country) <u>Kansas City, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel D. Baird</u>				14. MOTHER'S MAIDEN NAME <u>Eva Ferris</u>			
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 <u>Mrs. Frances Baird, 5306 W 58th</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arterio-sclerotic Heart Disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>4:30</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/>		SUICIDE <input type="checkbox"/>		HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY, a. m. p. m.		Hour Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>10-4-56</u> to <u>10-5-56</u> and last saw her <u>him</u> alive on <u>10-5-56</u> Death occurred at <u>1:30</u> A.M. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>H. F. Coulter M.D.</u>				22b. ADDRESS <u>Missouri, Kans.</u>		22c. DATE SIGNED <u>10-7-56</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>10-9-56</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Lenexa, Kansas</u>	
24. FUNERAL DIRECTOR <u>Wagner Funeral Home, 116 Mo.</u>				ADDRESS		25. DATE RECD. BY LOCAL REG. <u>10-8-56</u>	
				26. REGISTRAR'S SIGNATURE <u>Neve Yimshald</u>			

(Licensed Embalmer's Statement on Reverse Side)

Health,
Welfare
Public
Service300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

H. F. Coulter, M.D.

MEDICAL CERTIFICATION

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 *R. L. Hanschild*.....

Licensed Embalmer No. *3229*

P. O. Address *H. L. W.*

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.