

pt. Health,
& Welfare
S. Public
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S. 300
v. -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 causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED DEC 23 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44829
STATE FILE NUMBER
Registration District No. 157 Primary Registration District No. 5582 Registrar's No. 261

1. PLACE OF DEATH a. COUNTY <u>Jasper</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jasper</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Carthage (Jasper Twp)</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Carthage</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Fair Acres</u>		Length of stay in 1b	d. STREET ADDRESS <u>203 Fulton</u>		(If outside, give location) Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Ethel Baird</u>			4. DATE OF DEATH <u>Dec. 11, 1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-29-1889</u>	9. AGE (In years last birthday) <u>68</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Chickasha, Okla.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>McCall</u>			14. MOTHER'S MAIDEN NAME <u>Martha Keith</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>Luther Baird, Carthage, Mo.</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>Cerebral Thrombosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b) <u>Arterio sclerosis</u> <u>10 yrs +</u>
					DUE TO (c) <u>Hypertension</u> <u>10 yrs +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Myocarditis</u>					19. WAS AUTOPSY PERFORMED? <u>2</u> YES <input type="checkbox"/> NO <input checked="" 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 Hour <u>4:53</u> 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>March 1947</u> to <u>Dec 11, 1957</u> and last saw her <u>alive</u> on <u>Dec 11, 1957</u> . Death occurred at <u>4:53</u> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>B. Daulick</u> (Degree or title)			22b. ADDRESS <u>M. D. Carthage, Mo.</u>		22c. DATE SIGNED <u>12-12-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-14-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Park Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Carthage, Mo.</u>	
24. FUNERAL DIRECTOR <u>Ulmer Funeral Home, Carthage, Mo.</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>12-13-57</u>	26. REGISTRAR'S SIGNATURE <u>W. Clinton</u>	

(Licensed Embalmer's Statement on Reverse Side)

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 *Edwin C. Smith*.....

Licensed Embalmer No. 105

P. O. Address *Cartersville*

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.