

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012603

STATE FILE NUMBER

Registration District No. 55 Primary Registration District No. 3011 Registrar's No. 27

1. PLACE OF DEATH
a. COUNTY Carroll

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Carroll

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Carrollton Inside Limits Yes No

c. CITY OR TOWN Carrollton 0171 Inside Limits Yes No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 111 N. Virginia Length of stay in lb 10 yrs.

d. STREET ADDRESS (If outside, give location) 111 N. Virginia St. Reside on Farm Yes No

3. NAME OF DECEASED First Middle Last
Joseph William Baird

4. DATE OF DEATH Month Day Year
April 12, 1959

5. SEX Male 6. COLOR OR RACE White 7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH Nov. 23, 1889 9. AGE (In years last birthday) 69 IF UNDER 1 YEAR Months 4 Days 19 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Salesman

10b. KIND OF BUSINESS OR INDUSTRY Salesman

11. BIRTHPLACE (City and state or country) Bement ILL.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Ellis Baird 13b. MOTHER'S MAIDEN NAME Amelia Reeves 14. NAME OF HUSBAND OR WIFE Nessie Belle Baird.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No

16. SOCIAL SECURITY NO. 494-12-8829 17. INFORMANT Address Nessie Belle Baird (Carrollton Mo.)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypostatic Pneumonia (lobular)
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Cerebral Thrombosis
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 5810

INTERVAL BETWEEN ONSET AND DEATH 3 days
12 months

19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.

20d. INJURY OCCURRED WHILE AT NOT WHILE AT WORK 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 12-6-58 to 4-12-59 and last saw him alive on 4-12-59
Death occurred at 7:30 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Edward A. Smith D.O. 2 22b. ADDRESS 1076 9th St. Carrollton Mo. 22c. DATE SIGNED 4-15-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE 4-14-59 23c. NAME OF CEMETERY OR CREMATORY Gilead Cemetery 23d. LOCATION (City, town, or county) (State) Southwest of Carrollton Mo.

24. FUNERAL DIRECTOR ADDRESS Marshall F. Home Carrollton Mo. 25. DATE RECD. BY LOCAL REG. 4-14-59 26. REGISTRAR'S SIGNATURE Mr. Herbert Curved

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300
-57

FEB 20 1961

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 Samuel M. Marshall, Student Embalmer No. 511 working under my personal supervision.

Student Samuel M. Marshall
Signature of Student Embalmer

Signed R. M. Marshall

Licensed Embalmer No. 2525

P. O. Address Carrollton

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.