

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036544

FILED VS. NOV 5 1959/50

Registration District No. 5572 Primary Registration District No. 247 Registrar's No.

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rural Prairie	Length of stay in 1b 2 months	c. CITY OR TOWN Independence	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jackson County Hosp.		d. STREET ADDRESS (If outside, give location) 309 South Pleasant	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First **John** Middle **R.** Last **Baird Sr.** 4. DATE OF DEATH Month **October** Day **30** Year **1959**

5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/26/1881	9. AGE (last birthday) 78	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Miller** 10b. KIND OF BUSINESS OR INDUSTRY **General Mills** 11. BIRTHPLACE (City and state or country) **California, Mo.** 12. CITIZEN OF WHAT COUNTRY **U.S.A.**

13a. FATHER'S NAME **James W. Baird** 13b. MOTHER'S MAIDEN NAME **Ophelia Woods** 14. NAME OF HUSBAND OR WIFE **Ola Baird**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No** 16. SOCIAL SECURITY NO. **494-12-1563** 17. INFORMANT Address **Mrs. Ola Baird 309 S. Pleasant Indep. 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) **Arteriosclerotic heart disease**
DUE TO (b) **Generalized arteriosclerosis**
DUE TO (c) _____
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No Unknown

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 _____

20d. INJURY OCCURRED WHILE AT WORK 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 **8-27-59** to **10-30-59** and last saw her/him alive on **10-30-59**. Death occurred at **3:30** **A.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE **Philip J. Saper M.D.** (Degree or title) 22b. ADDRESS **his parents Mo** 22c. DATE SIGNED **10/30/59**

23a. URIAL CREMATION, REMOVAL (Specify) **Burial** 23b. DATE **Nov. 2, 1959** 23c. NAME OF CEMETERY OR CREMATORY **Centerview Cemetery** 23d. LOCATION (City, town, or county) **Centerview, Missouri**

24. FUNERAL DIRECTOR **Geo. C. Carson & Sons** ADDRESS **Indep. Mo.** 25. DATE RECD. BY LOCAL REG. **10-30-59** 26. REGISTRAR'S SIGNATURE **W.B. Langford**

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

