

FILED JUN 20 1946

State File No. \_\_\_\_\_

Registration District No. 89

Primary Registration District No. 5328

Registrar's No. 392

1. PLACE OF DEATH:

(a) County CLAY FORD - LIBERTY

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

(c) Name of hospital or institution: 1

(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 Clay

(c) City or town Leasburg - RURAL  
(If outside city or town limits, write "RURAL") 6260

(d) Street No. \_\_\_\_\_ (If rural, give location) 1

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME FRANK BAIR

3. (b) If veteran, name war ✓

3. (c) Social Security No. no

4. Sex Male 5. Color or race White

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

6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased Apr - 25 - 1870  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14 year 1946 hour 9 minute 15 A.

21. I hereby certify that I attended the deceased from May 13 1946 to May 14 1946 that I last saw him alive on May 13 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

8. AGE: Years 76 Months 0 Days 29 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace St. Louis Ohio  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 830

MOTHER FATHER

11. Industry or business \_\_\_\_\_

12. Name Jeremiah Bair

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

14. Maiden name Elizabeth Long

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

16. (a) Informant Mrs Della Bair

(b) Address Leasburg Mo

17. (a) Burial (b) Date thereof 5-16-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Canton

18. (a) Signature of funeral director Albert E Long

(b) Address Canton Mo

19. (a) 5-15-46 (b) H. J. Durbin M.D.  
(Date received local registrar) (Registrar's signature)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 0

23. Signature H. J. Durbin (M. D. or other) \_\_\_\_\_  
Address Leasburg Mo Date signed 5-15-46

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

RECEIVED

District Health Officer No. 5,

District File Number 646383

Date Filed 6.19.46

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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 Albert Long

Licensed Embalmer No. B504

P. O. Address Bausbow Mo.

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.