MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County: Gentry

Township: Athens

or

Village:

or

City: (NO. St.; Ward)

Registration District No. 309 File No. 29150

Primary Registration District No. 5427 Registered No. 47

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Charles Nelson Baldock

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	white	single

DATE OF BIRTH: July (Month) 8 (Day), 1901 (Year)

AGE: 17 yrs. 2 mos. 21 ds. | If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): at home

BIRTHPLACE (City or town, State or foreign country): Gentry Co. Mo.

PARENTS
NAME OF FATHER: C. A. Baldock
BIRTHPLACE OF FATHER (City or town, State or foreign country): Gentry Co. Mo.
MAIDEN NAME OF MOTHER: Clara B. Williams
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Gentry Co. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. A. Baldock

(ADDRESS) Albany Mo.

Filed Oct. 7, 1918. N. T. Martin REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Sep 29 (Month) (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from Sep 14, 1918, to Sep 29, 1918, that I last saw him alive on Sep 29, 1918, and that death occurred, on the date stated above, at 12 9 m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

1 01

(Duration) ___ yrs. ___ mos. 30 ds.

Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. H. Barger M. D.

Oct 6th 1918 (Address) Albany Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.
Where was disease contracted if not at place of death?
Former or usual residence

PLACE OF BURIAL OR REMOVAL: Grandview Cem. | DATE OF BURIAL: Oct 1, 1918

UNDERTAKER: H. W. Bare | ADDRESS: Albany Mo.

PLACE OF DEATH

MISSOURI STATE BOARD OF HEA

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County.....

Township ..... Registration District No..... File No.....

or

Village..... Primary Registration District No..... Registered No.....

or

City ..... (NO. ..... St.: ..... Ward)

[If death occu hospital or in give its NAME of street and nu

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... (Month) ..... (Day) , 1..... (Year)

AGE

.....yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or.....min.?

OCCUPATION

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE (City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER (City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191....., ...

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

..... (Month) ..... (Day)

I HEREBY CERTIFY, that I attended decease

....., 191....., to.....,

that I last saw h.....alive on.....,

and that death occurred, on the date stated above, at.....

The CAUSE OF DEATH* was as follows:

.....

.....

.....(Duration).....yrs.....mos.....

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mos.....

(Signed).....

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Cau (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSI RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIA
UNDERTAKER	ADDRESS