WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. 791 File No. 30731

or

Village ..... Primary Registration District No. 1003 Registered No. 8635

or

City St Louis Mo (NO. Lutheran Hospital St.; 10 Ward)

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

2 FULL NAME Louisa Kassel

**PERSONAL AND STATISTICAL PARTICULARS**

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Feb (Month) 23 (Day), 1867 (Year)

7 AGE: 51 yrs. 6 mos. 14 ds. If LESS than 1 day, ....hrs. or ....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country): Missouri

PARENTS

10 NAME OF FATHER: Chas Baugert

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

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Not Known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Kassel

(Address) Farrar Mo

15 Filed SEP 25 1918, 191 Max C. Starkloff Registrar

**MEDICAL CERTIFICATE OF DEATH**

2

16 DATE OF DEATH: Sept (Month) 14 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Aug 29, 1918, to Sept 14, 1918, that I last saw her alive on Sept 14, 1918, and that death occurred, on the date stated above, at 7:20 P.M.

The CAUSE OF DEATH* was as follows:

Hyperthyroidism 88

126

Exophthalmic Goitre

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Gall Stones

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) W. Hough M. D.

Sept 15, 1918 (Address) 330 Metropolitan Bldg.

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. 17 ds. In the State 51 yrs. 6 mos. 14 ds.

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

Former or usual residence Farrar Mo

19 PLACE OF BURIAL OR REMOVAL: Menfro Mo

DATE OF BURIAL: Sept 17, 1918

20 UNDERTAKER: Zugenheim Bros

ADDRESS: 2623 Cherokee

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

**1 PLACE OF DEATH**

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ..... St.; ..... Ward)

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

**2 FULL NAME** .....

**PERSONAL AND STATISTICAL PARTICULARS**

| 3 SEX | 4 COLOR OR RACE | 5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word) |
|---|---|---|
| | | |

6 DATE OF BIRTH

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

7 AGE ..... yrs. ..... mos. ..... ds.

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

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

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

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH

..... (Month) ....., 191..... (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....
that I last saw h..... alive on ....., 191.....,
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

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

CONTRIBUTORY .....
(Secondary)

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

(Signed) ..... M. D.

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

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

18 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 .....

| 19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL |
|---|---|
| | ....., 191..... |

| 20 UNDERTAKER | ADDRESS |
|---|---|
| | |

**WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD**

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