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. 30913

or

Village ..... Primary Registration District No. 1003 Registered No. 8855

or

City St Louis (NO. City Hospital St. 17 Ward)

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

2 FULL NAME 7008 David Baxley

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

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

6 DATE OF BIRTH: Dec (Month) 10 (Day), 1875 (Year)

7 AGE: 42 yrs. 9 mos. 8 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Labor 34
(b) General nature of industry business, or establishment in which employed (or employer): Day 92

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

PARENTS

10 NAME OF FATHER: M. H Baxley

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

12 MAIDEN NAME OF MOTHER: Lizzie Powell

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E Rowan

(Address) City Hospital

15 Filed SEP 23 1913, 191 Marc Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH 2

16 DATE OF DEATH: Sept (Month) 18 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 6, 1918, to Sept 18, 1918, that I last saw him alive on Sept 18, 1918, and that death occurred, on the date stated above, at 9 05 a.m.

The CAUSE OF DEATH* was as follows:

Transverse Myelitis of Spinal Cord

Syphilis 37

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

CONTRIBUTORY (Secondary) Chr. Valvular disease

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

(Signed) Emil E Heen M. D.

Sept 19, 1918 (Address) City Hospital

*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. 12 ds. In the State 15 yrs. ..... mos. ..... ds.

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

Former or usual residence 2621 Morgan

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL ....., 191....

20 UNDERTAKER: J. L. Edwards

ADDRESS: 1426 Carroll St

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) ..... (Day), 1..... (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) ..... (Day), 191..... (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

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.