LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

Registration District No. 21 File No. 36125
Primary Registration District No. 1003 Registered No. 9492

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

1 PLACE OF DEATH

County

Township or Village or City St Louis Mo (No. City Hospital St. 6 Ward) 8464

2 FULL NAME Elmer Trammell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: June 30 (Month) (Day) 1896 (Year)

7 AGE: 22 yrs. 3 mos. 12 ds. If LESS than 1 day, ... hrs. or ..... min.?

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

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

PARENTS
10 NAME OF FATHER: Oliver Trammel
11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Ill.
12 MAIDEN NAME OF MOTHER: Unknown
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ill.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF
(Informant) Otto A. Entsch
(Address) City Hospital

15 Filed OCT 13 1918, 191 Mark Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct. (Month) 12 (Day), 191 8 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct 9, 1918, to Oct 12, 1918, that I last saw him alive on Oct 12, 1918, and that death occurred, on the date stated above, at 8 00 a.m.

The CAUSE OF DEATH* was as follows:
Influenza 10
IIA
108 (Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Lobar Pneumonia
(Duration) yrs. mos. ds.
(Signed) Otto A. Entsch M. D.
Oct 12, 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 6 yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence 2305 Clark

19 PLACE OF BURIAL OR REMOVAL: Harrisburg Ill DATE OF BURIAL: Oct. 14, 1918

20 UNDERTAKER: E. J. Schnur ADDRESS: 2652 Chouteau

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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 .....

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.

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

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