LOCAL REGISTRAR'S RECORD DO NOT TEAR OFF

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.

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

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

36137

1 PLACE OF DEATH

County .....

Township ..... or Village ..... or City St Louis Mo (No. City Hospital St. 8 Ward) 8074

Registration District No. 791 Primary Registration District No. 1003

File No. 9504 Registered No. .....

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

2 FULL NAME Ellis Baughman

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

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

6 DATE OF BIRTH: Oct (Month) 1 (Day), 1899 (Year)

7 AGE: 19 yrs. ..... mos. 11 ds. If LESS than 1 day, ... hrs. or ..... min.?

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

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

PARENTS

10 NAME OF FATHER: Seaborn B Baughman

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

12 MAIDEN NAME OF MOTHER: Mary Higgin Cotton

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Otto R Fritsch
(Address) City Hospital

15 Filed OCT 13 1918, 191 Max C Starkoff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 12 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct 3, 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 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Influenza 10
11A
107A
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Emil R Geiger M. D.
Oct 13, 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. 7 ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence: No Home

19 PLACE OF BURIAL OR REMOVAL: Harrison Arkansas
DATE OF BURIAL: Oct 15 1918

20 UNDERTAKER: Frank Hellage
ADDRESS: 907 Chouteau

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

1 PLACE OF DEATH

County .....

Township..... or Village ..... or City..... (NO....., ...St.;.....Ward)

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

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

[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.