LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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. 781 File No. 36123
or
Village ..... Primary Registration District No. 1003 Registered No. 9552
or
City St Louis Mo (No. City Hospital St. 5 Ward) 8368

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

2 FULL NAME Leland Redman

**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 Feb. 17, 1883 (Month) (Day) (Year)

7 AGE 35 yrs. 7 mos. 26 ds. If LESS than 1 day, ....hrs. or ....min.?

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

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

PARENTS

10 NAME OF FATHER Jas. R. Redman

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Not known

12 MAIDEN NAME OF MOTHER Susie McKillan

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF
(Informant) Hospital Information
Geo. P. Fritsch
(Address) City Hospital

15 Filed OCT 14 1918, 191 Mark Starkoff Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH Oct 13, 1918 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct 9, 1918, to Oct 13, 1918, that I last saw him alive on Oct 13, 1918, and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

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

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

(Signed) Arnold Jerni M. D.
Oct 14, 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 3 yrs. ....mos. ....ds. In the State 6 yrs. ....mos. ....ds.
Where was disease contracted if not at place of death? .....
Former or usual residence Warwick Hotel

19 PLACE OF BURIAL OR REMOVAL Princeton Ind. DATE OF BURIAL Oct 14, 1918

20 UNDERTAKER Hanigan & Kirchner ADDRESS 7670 Morgan

# 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** .....

**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
....., 191.....
(Month) (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**

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.