S. P. Stowers

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

PLACE OF DEATH

County: Clay

Township: Gallatin
or
Village: ~~Linden~~
or
City: _____ (NO. _____, _____ St.; _____ Ward)

Registration District No. 196

Primary Registration District No. 5276a

File No. 38658

Registered No. _____

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

FULL NAME Odessa Cecil Baffard

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: white

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

DATE OF BIRTH: Jan (Month) 18 (Day), 1902 (Year)

AGE: 16 yrs. 9 mos. 26 ds.

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

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

BIRTHPLACE (City or town, State or foreign country): Clay Co. Mo.

PARENTS

NAME OF FATHER: James Elliott

BIRTHPLACE OF FATHER (City or town, State or foreign country): Clay Co. Mo.

MAIDEN NAME OF MOTHER: Lena Hudson

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Clay Co. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. C. V. Wright

(ADDRESS) Kansas City Mo.

Filed _____, 191__, _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Nov (Month) 13 (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 31, 1918, to Nov 13, 1918, that I last saw her alive on Nov 13, 1918, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Influenza of Lungs & Bowels

1498
1110

(Duration) _____ yrs. _____ mos. 7 ds.

Contributory (SECONDARY): Parturition

(Duration) _____ yrs. _____ mos. 14 ds.

(Signed) S. P. Stowers M. D.

Nov 17, 1918 (Address) North Kansas City Mo

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

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 _____

PLACE OF BURIAL OR REMOVAL: Barry Cemetery

DATE OF BURIAL: 11-14-1918

UNDERTAKER: L. F. Rollins

ADDRESS: Smithville

CAUSE OF DEATH is in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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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]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

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

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

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

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

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

MAIDEN NAME OF MOTHER

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

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

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.

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 .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191.....
UNDERTAKER	**ADDRESS**