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

13293

**1 PLACE OF DEATH**

County: Cape Girardeau

Township: ~~Cape Girardeau~~ Registration District No. 125 File No. 345

or

Village: ~~Cape Girardeau~~ Primary Registration District No. 3009 Registered No.

or

City: Cape Girardeau (No. St. Francis Hospital St., 3 Ward)

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

**2 FULL NAME** Claud Baggett

**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: April (Month) 19 (Day), 1900 (Year)

7 AGE: 18 yrs. 11 mos. 22 ds. If LESS than 1 day, ....hrs. or ....min.?

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

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

PARENTS

10 NAME OF FATHER: James Baggett

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

12 MAIDEN NAME OF MOTHER: Mattie Mattory

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Allen Baggett
(Address): Reynoldsville Ill

15 Filed 4/12 1919. Ora Bibbons Registrar

**MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH: April (Month) 11th (Day), 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from March 7 1919, to April 11th 1919, that I last saw h~~ave~~ alive on April 11th 1919, and that death occurred, on the date stated above, at 8 46 p.m.

The CAUSE OF DEATH* was as follows:

10
11A
110A Empyema
(Duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary): Influenza
(Duration) yrs. 2 mos. ds.

(Signed) John St. Avit Jr. M. D.
April 12th 1919. (Address) Cape Gir. Mo.

*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: Huck Pond Cemetery DATE OF BURIAL: April 13, 1919

20 UNDERTAKER: Lorberg F. & H. Co ADDRESS: Cape Gir. Mo.

# 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**

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