

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

Do not use this space.

1664

1. PLACE OF DEATH

County Jefferson

Registration District No. 699

File No. 255

Township 10th

Primary Registration District No. 1002

Registered No. 255

City Woodland

(No. 2540)

Ward 4

2. FULL NAME

Charles Lee Flemmings

(a) Residence, No. 2540 Woodland St., 4 Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U.S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Col.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Dec. 4 - 1928

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

1

14

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

Baby

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

10. NAME OF FATHER

Charles Logans

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

12. MAIDEN NAME OF MOTHER

Goldena Flemmings

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Tenn.

14.

INFORMANT

(Address)

Bertha Flemmings
2540 Woodland Ave

15.

FILED

1-18-29 m. m. Crow
Asst. REGISTRAR

21 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Jan. 18 1929

17.

I HEREBY CERTIFY That I attended deceased from

1/12/29 to 1/17/29, and that I last saw him alive on 1/17/29, and that death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

11A

107A

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (SECONDARY)

Dysentery

(duration) yrs. mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

San Francisco

19. DID AN OPERATION PRECEDE DEATH?

no

20. WAS THERE AN AUTOPSY?

no

WHAT TEST CONFIRMED DIAGNOSIS?

Clinical

(Signed)

M. R. Caldwell, M. D.

1/18/29 (address) 2432 Kirk

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state

(1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Highland Cemetery

1/18 1929

20. UNDERTAKER

ADDRESS

West, Appleton, Iowa Nov. 1928

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

