

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

Do not use this space.

22609

1. PLACE OF DEATH

County Holt
Township Union
City Union (No. _____)

Registration District No. 330
Primary Registration District No. 3017

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Lue Ellen Baugher

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)
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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>H. F. Baugher</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Jan 9, 1893</u>		
7. AGE	YEARS <u>57</u>	MONTHS <u>5</u>
	DAYS <u>28</u>	If LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>House wife</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
Missouri

PARENTS	10. NAME OF FATHER <u>Thurston Belshe</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Virginia</u>
	12. MAIDEN NAME OF MOTHER <u>Barb Hill</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Missouri</u>

14. INFORMANT H. F. Baugher
(Address) Union Mo.

15. FILED July 15 1930 E. A. Duffly REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 7 1930

17. I do HEREBY CERTIFY, That I attended deceased from _____, 1930, to July 7, 1930, that I last saw her alive on July 7, 1930, and that death occurred, on the date stated above, at 8:30 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
cerebral hemorrhage
92A
97
(duration) _____ yrs. _____ mos. 3 ds.
CONTRIBUTORY arterio-sclerosis
(SECONDARY) (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED? at home
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
Leit's test
(Signed) _____, M. D.
July 8, 1930 (Address) Union Mo.

*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 <u>Maple Grove</u>	DATE OF BURIAL <u>7/9/ 1930</u>
20. UNDERTAKER <u>W. H. Ross</u>	ADDRESS <u>Union Mo.</u>

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 should be given.

