

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
 JAN 27 1941
 609

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. 44110
 Registrar's No. 46

Registration District No. 609

Primary Registration District No. 6130

1. PLACE OF DEATH:
 (a) County Janey
 (b) City or town Hollister
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 years. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State mo (b) County Janey
 (c) City or town Hollister (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME William a. Baughman
3. (b) If veteran, name war _____ **3. (c) Social Security** No. _____

4. Sex m **5. Color or race** Am. **6. (a) Single, widowed, married, divorced** Child
6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if alive** _____ years
7. Birth date of deceased July 7 - 1937
 (Month) (Day) (Year)

8. AGE: Years 3 Months 5 Days 13 If less than one day _____ hr. _____ min.

9. Birthplace Hollister mo
 (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name Dorris Baughman
13. Birthplace Harrison ark.
 (City, town, or county) (State or foreign country)
14. Maiden name Clara Lewallen
15. Birthplace Hollister mo
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Dorris Baughman
(b) Address Hollister mo

17. (a) Place: burial or cremation Gables Knob **(b) Date thereof** 12-21-40
 (City or town) (County) (State) (Month) (Day) (Year)

18. (a) Signature of funeral director none
(b) Address _____

19. (a) 12-21-40 **(b)** John H. Baxter
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec day 20 year 1940 hour 4 minute A.M.
21. I hereby certify that I attended the deceased from Dec 20, 1940, to Dec 20, 1940
 that I last saw him alive on Dec 20, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Diphtheria
 Duration 2 days
 Due to _____
 Due to _____
 Other conditions (include pregnancy within 3 months of death) 10

Major findings:
 Of operations _____
 Of autopsy none
PHYSICIAN
 Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
 While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature J. P. E. Heltzer (M. D. or other) D.O.
Address Branson mo **Date signed** Dec 20

RECEIVED

District Health Officer No. 0;

District File Number 141-3088

Date Filed JAN 3 - 1947

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 44110

Registration District No. 859

Primary Registration District No. 6130

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Stacy
(b) City or town Clifton, P.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Wm A. Baughman

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color White 6. (a) Single, widowed, married, divorced, child

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>23</u>	<u>5</u>	<u>13</u>	hr. min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 12-21-40 (b) John H. Baxter
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH _____ month Dec day 20
year 1930 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature E E Giltner (M. D. or other)

Address Oranston Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

