

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-033984
STATE FILE NUMBER

FILED SEP 22 1958

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8425

300
1-57

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri | | c. CITY OR TOWN Lemay 4860 | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL | | d. STREET ADDRESS 2108 Telegraph Road | |
| Length of stay in lb 15 days | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |

| | | | | | |
|--|--|--|---|--|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last LOGAN HERBERT BAUGHMAN | | | 4. DATE OF DEATH Month Day Year AUGUST 31, 1958 | | |
|--|--|--|---|--|--|

| | | | | | | |
|----------------|---------------------------|--|------------------------------------|---------------------------------------|--------------------------------|--------------------------------|
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 5, 1886 | 9. AGE (In years last birthday) 72 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
|----------------|---------------------------|--|------------------------------------|---------------------------------------|--------------------------------|--------------------------------|

| | | | |
|---|--|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photo-Engraver-Retired | 10b. KIND OF BUSINESS OR INDUSTRY St. Louis Post-Dispatch | 11. BIRTHPLACE (City and state or country) Bryant Arkansas | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
|---|--|---|--|

| | | |
|--------------------------------------|--|---------------------------------------|
| 13a. FATHER'S NAME Lewis Baughman | 13b. MOTHER'S MAIDEN NAME Cynthia Boyer | 14. NAME OF HUSBAND OR WIFE Teresa |
|--------------------------------------|--|---------------------------------------|

| | | | |
|---|--|---------------------------------------|-------------------------------|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Peace time 1913 | 16. SOCIAL SECURITY NO. 488-03-0850 | 17. INFORMANT Mrs. Teresa Baughman | Address 2108 Telegraph Rd. |
|---|--|---------------------------------------|-------------------------------|

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Larynx with metastases | | INTERVAL BETWEEN ONSET AND DEATH 6 years |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

| | |
|---|--|
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 161x |
|---|--|

| | | | |
|---|---|--|---|
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION COUNTY STATE |
|---|---|--|---|

| | |
|---|--|
| 21. I attended the deceased from 8/15/58 to 8/31/58 and last saw him alive on 8/31/58 Death occurred at 8:45 a.m. on the date stated above; and to the best of my knowledge, from the causes stated. | |
|---|--|

| | | |
|--|---------------------------------|-----------------------------|
| 22a. SIGNATURE FR Bradley (Degree or title) M. D. | 22b. ADDRESS BARNES HOSPITAL | 22c. DATE SIGNED 8/31/58 |
|--|---------------------------------|-----------------------------|

| | | | |
|--|----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE Sept. 3, 1958 | 23c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cemetery | 23d. LOCATION (City, town, or county) (State) 7901 Gravois ave. St. L. Co. Mo. |
|--|----------------------------|---|---|

| | | |
|--|---|--|
| 24. FUNERAL DIRECTOR ADDRESS C. Hoffmeister Mortuaries 787 1/2 S. Broadway | 25. DATE RECD. BY LOCAL REG. SEP 2 '58 | 26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. S.P. |
|--|---|--|

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Lee C. Branson*

Licensed Embalmer No. *4764*

P. O. Address *St. Louis, Mo*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. • •

If this body is not embalmed, fact should be so stated above.