

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

Do not use this space.

19743

1. PLACE OF DEATH

County Lackson
Township Washington
City Dodson

Registration District No. 404
Primary Registration District No. 8038
(No. 1703 East 80)

File No. _____
Registered No. 31
St. _____ Ward _____

2. FULL NAME

Albert H Baumgardner

(a) Residence. No. 1703 East 80 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

Male

4. COLOR OR RACE

White

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

Widowed

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

Mrs. A. H. Baumgardner

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

Mar-6-1863

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
77	2	28	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Painter
(b) General nature of industry, business, or establishment in which employed (or employer). Retired
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Pa

10. NAME OF FATHER

Geo Baumgardner

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Pa

12. MAIDEN NAME OF MOTHER

Carrie Trailer

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Kan

14.

INFORMANT Clyde H. Baumgardner
(Address) 6012 Marty Ave. R.F. No. 1, CK

15.

FILED 6.18.1930 B.F. Foreman
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June-3-1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 12, 1929, to June 3, 1930
that I last saw him alive on June 3, 1930, and that death occurred, on the date stated above, at 11:30 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

of Angina Pectoris
(duration) yrs. ✓ mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) Leon Jones, M. D.
6/30, 19 (Address) 802 + Paseo

*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

L.C. Co Kansas June 4 1930

20. UNDERTAKER

ADDRESS

A.P. Doehler 1415 E 15

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.

48
61

65
2

303

