

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

JUN 15 1940

Registration District No. 85

Primary Registration District No. 4228

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Howell

(b) City or town Willow Springs. Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
2
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Howell

(c) City or town Willow Springs
0 (If outside city or town limit, write "RURAL")

(d) Street No Dick (If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Mrs. John W. Baughman 255

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 9
year 40 hour 9:15 minute _____ P. M.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife John W. Baughman

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

7. Birth date of deceased Sept-15th. 1871
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 4-8
1940, to 5-9- 1940
that I last saw her alive on 5-9- 1940
and that death occurred on the date and hour stated above.

8. AGE: Years 68 Months 7 Days 24
If less than one day _____ hr. _____ min.

Immediate cause of death Carcinoma of Colon Duration 6 mos

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

Due to _____

Due to 46

10. Usual occupation Cafe Operator

Other conditions Chr. cholecystitis
(Include pregnancy within 3 months of death)

11. Industry or business Cafe

12. Name Mt Evens

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

14. Maiden name Dont Know

16. Birthplace Dont Know
(City, town, or county) (State or foreign country)

16. (a) Informant Jas Baughman

(b) Address Willow Springs. Mo.

17. (a) Burial (b) Date thereof 5-12-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetary

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

18. (e) Signature of funeral director 345

(b) Address Willow Springs. Mo.

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

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

(b) Date of occurrence _____

19. (a) 5-12-40 (b) Nanelle Ferguson
(Date received local registrar) (Registrar's signature)

(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 D. Callahan (M. D. or other) 1

Address Willow Springs, Mo. Date signed 5-12-40

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

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.

RECEIVED

District Health Officer No. 5,

District File Number 640 670

Date Filed 07.24.0

Signed

J. R. Burns

Licensed Embalmer No. 1847

P. O. Address Willow Springs, 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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 18582

Registration District No. 385

Primary Registration District No. 4228

Registrar's No.

1. PLACE OF DEATH:

(a) County: Howell
(b) City or town: Willow Springs
(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
In this community: years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State: (b) County:
(c) City or town:
(d) Street No.:
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME

Mrs. BELL

Baughman

MEDICAL CERTIFICATION

DATE OF DEATH: Month 5 day 9
year 1940 hour minute M.

3. (b) If veteran, name war: 3. (c) Social Security No.:
4. Sex: 7 5. Color or race: W
6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife: 6. (c) Age of husband, or wife, if alive:
7. Birth date of deceased: (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 19 to 19 that I last saw him alive on and that death occurred on the date and hour stated above.
Immediate cause of death

8. AGE: Years 68 Months 7 Days 24 If less than one day hr. min.

Due to:
Due to:
Other conditions:
Major findings:
Of operations:
Of autopsy:

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)

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) (a) Means of injury:

16. (a) Informant: (b) Address:
17. (a) (Burial, cremation, or removal) (b) Date thereof: (Month) (Day) (Year)
(c) Place: burial or cremation:
18. (a) Signature of funeral director: (b) Address:
19. (a) (Date received local registrar) (b) (Registrar's signature)

23. Signature: C. T. Callikar (M. D. or other)
Address: Willow Springs Date signed: Mrs

SUPPLEMENTAL

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

Rem

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 18682

Registration District No. 385

Primary Registration District No. 4228

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Howell
(b) City or town Willow Springs
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Mrs BELLE Baughman

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced u

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 68 Months 7 Days 24 If less than one day _____ 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: (Month) _____ (Day) _____ (Year) _____

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 5-12-40 (b) Naulette Ferguson
(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) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 - day 9
year 1940 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 W. T. Callahan (M. D. or other) _____

Address Willow Springs _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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