No. 2
1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15306

FILED MAY 23 1948

Registration District No. ..... Primary Registration District No. 3000 Registrar's No. 147

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

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Kirksville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Kevin Smith O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 25 days (Specify whether
In this community 25 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Schuyler 98
(c) City or town Lancaster 0
(If outside city or town limits, write "RURAL")
(d) Street No. none 0
(If rural, give location)
(e) Citizen of foreign country? XXX (Yes or No) 1
If yes, name country XXXX

3. (a) PRINT FULL NAME IDA MAE BAUGHN

3. (b) If veteran, name war none
3. (c) Social Security No. none

4. Sex FE 1
5. Color or race W
6. (a) Single, widowed, married, divorced Widowed 5
6. (b) Name of husband or wife Chas Baughn
6. (c) Age of husband or wife if alive Dead years
7. Birth date of deceased July (Month) 8 (Day) 1869 (Year)

8. AGE: Years 78 Months 10 Days 6 If less than one day ..... hr. ..... min.

9. Birthplace Schuyler Co (City, town, or county) MO (State or foreign country) 0
10. Usual occupation Housewife
11. Industry or business XXX

FATHER
12. Name Geo Maxwell
13. Birthplace (City, town, or county) Ind. (State or foreign country) 1

MOTHER
14. Maiden name Caroline Jane Davis
15. Birthplace (City, town, or county) Ind. (State or foreign country) 1

16. (a) Informant Otis Baughn
(b) Address Lancaster MO
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 15-48 (Month) (Day) (Year)
(c) Place: burial or cremation Arni
18. (a) Signature of funeral director P O Fenton
(b) Address Lancaster MO
19. (a) 5-18-48 (Date received local registrar) (b) Kate Lambert (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14 year 1948 hour 12 minute 45 A.M.

21. I hereby certify that I attended the deceased from April 4, 1948 to May, 1948
that I last saw her alive on 5/13, 1948
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death — Pneumonia hypostatic —	1 wk
Due to Broken hip	5 wks
Due to General debility & weakness	

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause of which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? (Specify type of place)
While at work? (e) Means of injury 0

23. Signature George E. Grim (M. D. or other) MD
Address Kirksville Missouri Date signed 5/18/48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer
District File Number 5-48
MAY 26 1948
Date Filed

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 Russell Fenton

Licensed Embalmer No. 3705

P. O. Address Lancaster

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

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

S. No. 2B
M—3-45
P 1 X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 147

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Kirksville (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)

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

3. (a) PRINT FULL NAME Ida M. Baughn
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive (Years)
7. Birth date of deceased July (Month) 8 (Day) 1869 (Year)
8. AGE: Years 78 Months 10 Days If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Day 14 year 1948 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above. Duration
Immediate cause of death
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

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) Accident
(b) Date of occurrence 4-4-48
(c) Where did injury occur? Home in Schuyler (City or town) (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)
While at work? Yes (?) (e) Means of injury fall
23. Signature George E. Grim (M. D. or other) MD
Address Date signed

SUPPLEMENTARY

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

S-15306