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.

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

PLACE OF DEATH

County Monitaur

Township Morgan or Village ____ or City ____ (NO. ____ St.: ____ Ward)

Registration District No. 1895 File No. 34842

Primary Registration District No. 5770 Registered No. D 14

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Louis Edwards Elmlinger

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Sole

DATE OF BIRTH: Oct (Month) 17 (Day) 1918 (Year)

AGE: ____ yrs. ____ mos. 11 ds. | If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): —

BIRTHPLACE (City or town, State or foreign country): Morgan Co. Mo.

PARENTS

NAME OF FATHER: Chas. Jos Elmlinger

BIRTHPLACE OF FATHER (City or town, State or foreign country): Henry Co., Mo

MAIDEN NAME OF MOTHER: Henrietta Schmidt

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Morgan Co., Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas Jas. Elmlinger

(ADDRESS) Clarksburg Mo.

Filed Oct 28 1918 H C Grundlingen REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Oct (Month) 28 (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 11, 1918, to Oct 28, 1918, that I last saw him alive on Oct 13, 1918, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Primalin Bronch-
159

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY) ____ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) H C Grundlingen M. D.

Oct 29 1918 (Address) Clarksburg Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

PLACE OF BURIAL OR REMOVAL: St Andrews Cem Tipton Mo

DATE OF BURIAL: Oct 29 1918

UNDERTAKER: Dunhoff

ADDRESS: Tipton Mo

PLACE OF DEATH

County_____

Township _____
or
Village_____
or
City _____ (NO._____, _____ St.:_____ Ward)

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

Registration District No._____ File No._____

Primary Registration District No._____ Registered No._____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME_____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

_____ (Month) _____, *1*_____ (Day) (Year)

AGE

_____yrs._____mos._____ds.

If LESS than 1 day, ____hrs. or ____min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)_____

(ADDRESS)_____

Filed _____, 191__, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____, *191*__
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191__, to _____, 191__, that I last saw h_____ alive on _____, 191__, and that death occurred, on the date stated above, at _____m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____(Duration)_____yrs._____mos._____ds.

Contributory_____
(SECONDARY)

_____(Duration)_____yrs._____mos._____ds.

(Signed)_____ M. D.

_____, 191__ (Address)_____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death_____yrs._____mos._____ds. In the State_____yrs._____mos._____ds.

Where was disease contracted if not at place of death? _____

Former or usual residence_____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	_____, 191__
UNDERTAKER	ADDRESS

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.

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