

PLACE OF DEATH

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

County North
Township Delchell
or
Village
City (NO. St. Ward)

Registration District No. 903File No. 38185Primary Registration District No. 621Registered No. 21

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

FULL NAME

Margaret C Hagans

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SPOUSE Married
WIDOWED OR DIVORCED (If file the word)
DATE OF BIRTH Jan 13 - 24 1921
(Month) (Day) (Year)
AGE 91 yrs. 10 mos. 14 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION

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

Housewife

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

BIRTHPLACE

(City or town, State or foreign country)

St Charles Co Mo

NAME OF FATHER

Paul Grimes

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Douglas Mo

MAIDEN NAME OF MOTHER

Mrs Hild

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Douglas Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE by

(Informant)

Mrs Scott Hagans O Prugh

(ADDRESS)

Grant City Mo

Filed

Nov 30 1912 John Andrews
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

November 27 1912
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 1912, to Nov 26 1912, that I last saw her alive on Nov 26 1912, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

97 Edema of Lungs
111B and Semility
162 Arterio Sclerosis

(Duration) yrs. 6 mos. 0 ds.

Contributory (SECONDARY)

Semility
(Duration) yrs. 2 mos. 0 ds.

(Signed)

J. R. Phipps M. D.
Nov 27 1912 (Address) Grant City, 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

Isadoro Cem

DATE OF BURIAL

Nov 28 1912

UNDERTAKER

O Prugh

ADDRESS

Grant City Mo

PLACE OF DEATH

County _____

Township _____

or _____

Village _____

or _____

City _____

(NO. _____)

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

St. _____ Ward _____

[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) _____ (Day) _____ (Year) _____

AGE

IF LESS than 1 day	hrs.	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) _____

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

(Month) _____ (Day) _____ (Year) _____

I HEREBY CERTIFY that I attended deceased from _____, 191 _____, to _____, 191 _____,

that I last saw him 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.

(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. 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

UNDERTAKER

ADDRESS