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

PLACE OF DEATH

County: Pettis

Township: ..... or

Village: ..... or

City: Sedalia (No. 1503 S. Harrison St.; Ward)

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

Registration District No. 648 File No. 17352

Primary Registration District No. 3032 Registered No. 124

FULL NAME James M. Agan

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
M.	White	Married

DATE OF BIRTH: Jan. 15, 1832 (Month) (Day) (Year)

AGE: 81 yrs. 4 mos. 10 ds. If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer - W
(b) General nature of industry, business, or establishment in which employed (or employer): -0

BIRTHPLACE (City or town, State or foreign country): Tenn.

PARENTS
NAME OF FATHER: Jno. S. Agan -
BIRTHPLACE OF FATHER (City or town, State or foreign country): Ky -
MAIDEN NAME OF MOTHER: Jane E. Gardner
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ky -

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. F. Wilcox

(ADDRESS) Hampton Mo.

Filed May 24 1913. H. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: May (Month) 25 (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from May 23, 1913, to May 25, 1913, that I last saw him alive on May 25, 1913, and that death occurred, on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

89 A.

(Duration) — yrs. — mos. 2 ds.

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

(Signed) W. A. Brookemyer M. D.

5/26, 1913. (Address) Sedalia 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	DATE OF BURIAL
Hampton Iowa	5-26, 1913
UNDERTAKER	**ADDRESS**
Sedalia Nutt & Co	Sedalia Mo

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
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CERTIFICATE OF DEATH

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.

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village..... Primary Registration District No. ..... Registered No. .....

or

City .....(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), 1.....(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

.....(Month) .....(Day), 191.....(Year)

I HEREBY CERTIFY, that I attended deceased from .....(Month) .....(Day), 191....., to .....(Month) .....(Day), 191.....,

that I last saw h.....alive on .....(Month) .....(Day), 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**