MARGIN RESERVED FOR BINDING

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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

1 PLACE OF DEATH

County: Monroe

Township: Marion
or
Village:
or
City: (NO. , St., Ward)

Registration District No. 579 File No. 22755

Primary Registration District No. 3776 Registered No.

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

2 FULL NAME John J. Pagett

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: June (Month) 29 (Day) 1845 (Year)

7 AGE: 72 yrs. 4 mos. 10 ds.

If LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE (City or town, State or foreign country): Randolph Co Mo

PARENTS

10 NAME OF FATHER: John Pagett

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

12 MAIDEN NAME OF MOTHER: Elizabeth Stephens

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Otto Pagett

(Address) Madison Mo

15 Filed 6/9 1917 W W Eubank Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June (Month) 9 (Day) 1917 (Year)

17 I HEREBY CERTIFY, that I attended deceased from June 3 1917, to June 9 1917, that I last saw him alive on June 8 1917, and that death occurred, on the date stated above, at 12 30 a.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

10 1/2 A

1 D

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Asthma

(Duration) Don't Know yrs. mos. ds.

(Signed) J. Brainard M. D.

June 14, 1917 (Address) Duncan Bridge

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

18 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

19 PLACE OF BURIAL OR REMOVAL: Hurse Cemetery

DATE OF BURIAL: 6/10 1917

20 UNDERTAKER: Fred A. Thompson

ADDRESS: Madison Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

Revised United States Standard Certificate of Death

Approved by U. S. Census and American Public Health Association

MISSOURI STATE BOARD OF H
BUREAU OF VITAL STATISTIC
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No .....
or
City ..... (NO. ....., ... St.; ..... Ward)

If des hospital give its of street

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ..... (Day), 1..... (Year)

7 AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

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

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day)

17 I HEREBY CERTIFY, that I attended de

....., 191....., to .....

that I last saw h.....alive on .....

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....m

CONTRIBUTORY .....
(Secondary)

..... (Duration).....yrs.....m

(Signed) .....

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Viole (1) Means of Injury; and (2) whether Accidental, Suicidal

18 LENGTH OF RESIDENCE (For Hospitals, Institution or Recent Residents)

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

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

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BU

20 UNDERTAKER

ADDRESS

"Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor"