

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

Do not use this space.

40032

1. PLACE OF DEATH

County.....

Registration District No.....

791

Township.....

Primary Registration District No.....

1003

City.....

(No. Enroute to Hospital)

File No.....

Registered No. 12052

St. Ward)

2. FULL NAME

(a) Residence No. 5200 Lotus St. 6 Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *widowed*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF *Fannie Bagby*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Feb. 12 1866*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
60 10 7

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Electrician Mary*
(b) General nature of industry, business, or establishment in which employed (or employer) *P.O. Bldg.*
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Collinsville Ill*

10. NAME OF FATHER *Daniel W. Bagby*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Ill*

12. MAIDEN NAME OF MOTHER *Caroline Magfield*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Ill*

14. INFORMANT *D. W. Bagby*
(Address) *6823 Miss.*

15. FILED *1926* *May 6 Starkloff*
19. REGISTAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *12/19* 19 *26*

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19..... that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hemorrhage of Brain, due to Fracture Skull Struck with Blunt Instrument
175 B
CONTRIBUTORY (SECONDARY) *Homicide*

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *H. W. Fath*

*State the DISEASE CAUSING DEATH, or deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Valhalla *May 22 1926*

20. UNDERTAKER ADDRESS

Provest Nut Co *3710 N Grand*

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.

