

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

Do not use this space
15312

2081

1. PLACE OF DEATH

County Jackson Co. Registration District No. _____
Township Harri Primary Registration District No. _____
City St. C. Mo. (No. 1532 Bennington) _____ St. _____ Ward _____

File No. _____
Registered No. _____

2. FULL NAME William Friedrich Fagan

(a) Residence. No. 1532 E 16th Bennington 12 Ward. _____
(Usual place of abode) _____ (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 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 Whi
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 12 - 1906

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>20</u>	<u>9</u>	<u>7</u>		

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

9. BIRTHPLACE (CITY OR TOWN) Saginaw Mich.
(STATE OR COUNTRY) _____

10. NAME OF FATHER Fred Fagan

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Humboldt Mich.
(STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Lidia Blower

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Jamestown Mich.
(STATE OR COUNTRY) _____

14. INFORMANT Mrs Fagan Brant
(Address) 1532 Bennington

15. FILED 5/21/27 M M Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 19 1927

17. I HEREBY CERTIFY, That I attended deceased from april 1st, 1927, to May 18, 1927, that I last saw him alive on May 18, 1927, and that death occurred, on the date stated above, at 5:32 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute endocarditis

99c 90 10
(duration) _____ yrs. _____ mos. 30 da.
CONTRIBUTORY Chr. Myocarditis
(SECONDARY) (duration) ? yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? _____

19. DID AN OPERATION PRECEDE DEATH? No. DATE OF _____
WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) D. D. Edwards, M. D.

(Address) 4800 E 27th
*State the DISEASE CAUSING DEATH, or in 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 Wt Washington Con. DATE OF BURIAL May 21 1927

20. UNDERTAKER Rose & Co. ADDRESS 15th Jackson

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.

Dr. Edwards
3526 Indiana
24th St. & Bloch