

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

Do not use this space.

✓ 20349

1. PLACE OF DEATH

County Scott
Township Wyness
City Deshler (No.)

Registration District No. 818
Primary Registration District No. 5762

File No.
Registered No. 57
St. Ward)

2. FULL NAME

John Frederick Bagwell

(a) Residence. No. St. Ward.
(Usual place of abode)

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) Married, wife dead

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary C. May Bagwell

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 6, 1855

7. AGE YEARS 71 MONTHS 11 DAYS 10 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Physician
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Ackerman
(STATE OR COUNTRY) Mississippi

10. NAME OF FATHER Perry Bagwell

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

12. MAIDEN NAME OF MOTHER Mary Ernest

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

14. INFORMANT Josephine Vieth
(Address) Deshler, Missouri

15. June 20, 1927 F. S. Verner REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6/19 1927

17. I HEREBY CERTIFY, That I attended deceased from 9:15 a.m. to 1:15 p.m., 1927, that I last saw him alive on June 19, 1927, and that death occurred, on the date stated above, at 5:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Diabetic Mellitus

52 (duration) 6 yrs. mos. da.

CONTRIBUTORY (SECONDARY) Paralysis
(duration) yrs. mos. da. 3

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical symptoms
(Signed) R. H. Chapman, M. D.
, 19 (Address) Charlottesville, Va.

*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 Maynard Cemetery DATE OF BURIAL June 20 1927

20. UNDERTAKER R. R. Dempster ADDRESS 512 East 10th St.

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.

Miss
Katherine
Miss
Miss

Miss

Miss

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Scott Registration District No. 818 File No. _____
Township Piqua Primary Registration District No. 5762 Registered No. 57
City _____ (Name) _____ St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ St. _____ 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

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

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER _____

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

14.

INFORMANT _____
(Address) _____

15.

FILED Aug 18th 27 J. D. Vernon
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, that I attended deceased from _____, 19____, to _____, 19____, and that I last saw him _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Liquor Mellitus

CONTRIBUTORY (SECONDARY) Paralysis, Apoplexy
(Cerebral Hemorrhage)

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) _____, M. D.
, 19____ (Address) _____

*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 _____

DATE OF BURIAL _____

20. UNDERTAKER _____

ADDRESS _____

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 COMPLETE AS PRESCRIBED BY LAW

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