

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

Do not use this space.

18194
2239

1. PLACE OF DEATH

County Jackson
Township Low
City St. Louis

Registration District No. 399
Primary Registration District No. 1002
(No. Mercy Hospital)

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Dolly M. Stagner
(a) Residence. No. Granette Ark. St. _____ Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5-28-26

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
2 11 16

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Granette, Ark
(STATE OR COUNTRY) Ark

10. NAME OF FATHER Thomas Stagner

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

12. MAIDEN NAME OF MOTHER Hattie Gagg
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Mo

14. INFORMANT Mrs. Granette
(Address) Granette Ark

15. FILED 5/15 1929 M. M. Crowe
asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-14 1929

17. I HEREBY CERTIFY, That I attended deceased from 5/13, 1929 to 5/14, 1929 that I last saw him alive on 5/14, 1929 and that death occurred, on the date stated above, at 2:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Toxemia - & Tracheal edema from Foreign body
1948
69B (duration) _____ yrs. _____ mos. 10 ds.

CONTRIBUTORY (SECONDARY) Foreign body in Trachea (duration) _____ yrs. _____ mos. 10 ds.

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

DID AN OPERATION PRECEDE DEATH? Yes DATE OF 5/14/29
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Bronchoscopic Exam
(Signed) Alford Stockwell, M. D.
5/15, 1929 (Address) 623 Myrtle Bldg

*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 Granette Ark DATE OF BURIAL May 15 1929

20. UNDERTAKER Mrs. C. L. Farwell ADDRESS City 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.

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