

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

Do not use this space.

8849

1. PLACE OF DEATH

County Jackson
Township Blue
City Leeds

Registration District No. 399
Primary Registration District No. 165
(No. Leeds Hospital)

File No. _____
Registered No. 1227
St. _____ Ward _____

2. FULL NAME F. Lagg, Columbia

(a) Residence. No. 1410 Lydia St. 2 Ward. T. B. Amner
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. 3 mos. 0 ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds. _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE colored 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) May 14, 1914

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
15 10 12

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

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

PARENTS
10. NAME OF FATHER F. Lagg, Columbia
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Miss
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Louise Miller
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Miss
(STATE OR COUNTRY)

14. INFORMANT T. B. Hospital
(Address) Leeds, Mo.

15. FILED 720 1930 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-18 1930

17. I HEREBY CERTIFY, That I attended deceased from 3-8, 1930, to 3-18, 1930 that I last saw him alive on 3-18, 1930 and that death occurred, on the date stated above, at 1:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Pulmonary Tuberculosis
23A
(duration) 0 yrs. 7 mos. 3 ds.

CONTRIBUTORY (SECONDARY) none
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH unknown

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical Laboratory

(Signed) Edwin H. Lee, M. D.

May 10, 1930 (Address) 1830 Vine St

*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 Highland DATE OF BURIAL Mar 20, 1930

20. UNDERTAKER Walter Bros ADDRESS 1729 Lydia

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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1410 Tyceni, Ann

Miss Magruder (Mother)

Miss Lavinia W. Adams,