

REC'D JUL 12 1938

**MISSOURI STATE BOARD OF HEALTH**  
**BUREAU OF VITAL STATISTICS**  
**CERTIFICATE OF DEATH**
791  
100820697  
Do not use this space.

## 1. PLACE OF DEATH

(a) County..... Registration District No.....  
 (b) Township..... Primary Registration District No.....  
 (c) City St. Louis (d) Street No. City Hospital No. 1 St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

D. 2866

Baby Daggett

230

## 2. PRINT FULL NAME

(a) Residence, No. 1749 Waverly St. [23] (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 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 29, 1938

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

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc. nil  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Missouri13. NAME James Daggett 014. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri 015. MAIDEN NAME Mae Thompson 016. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri17. INFORMANT (ADDRESS) Hosp. Info M. Kent18. BURIAL, CREMATION, OR REMOVAL PLACE City Cemetery DATE 6-30-3819. FUNERAL DIRECTOR (NAME) (ADDRESS) W. Van Buren  
C. N. I.20. FILED JUN 29 1938 J. D. Riedel Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/29/38 1922. I HEREBY CERTIFY, That I attended deceased from 5/29/38, 19..... to..... 5/29/38, 19.....

I last saw him alive on 5/29/38, 19..... Death is said to have occurred on the date stated above, 7.30 am.  
 The principal cause of death and related causes of importance were as follows:

stillborn

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy? N.O.23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?

If so, specify.....  
 (Signed) John F. Flynn, M. D.  
 (Address) City Hospital No. 1

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, .....

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

STATE OF MISSISSIPPI  
DEPARTMENT OF HEALTH  
BUREAU OF PUBLIC HEALTH  
EMBALMERS  
1911

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

Do not use this space.

**1. PLACE OF DEATH**

(a) County.....

Registration District No.....

(b) Township.....

Primary Registration District No.....

(c) City.....

(d) Street No. CITY HOSPITAL NO. 1 Registered No. 5836 St.

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in Hospital or Institution, write its name instead of street and number)

**2. PRINT FULL NAME**

(a) Residence, No. 1749 Waverly St. 23

(Usual place of abode, if no street address, write county or city)

(If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

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

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. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. ....  
9. Industry or business in which work was done, as saw mill, bank, etc. ....  
10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) .....

FATHER 13. NAME .....

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) .....

MOTHER 15. MAIDEN NAME .....

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) .....

17. INFORMANT (ADDRESS) .....

18. BURIAL, CREMATION, OR REMOVAL

PLACE ..... DATE ..... 19 .....

19. FUNERAL DIRECTOR (NAME) (ADDRESS) .....

20. FILED Jul. 12 1938 J. B. Brudeck Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) MAY 29 1938

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw him..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 7:30 A.M.

The principal cause of death and related causes of importance were as follows:

STILLBORN

Date of onset

Other contributory causes of importance: .....

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify .....

(Signed)....., M. D.

(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.

SUPPLEMENTARY

SUPPLEMENTARY

SUPPLEMENTARY

5-20697

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, .....

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

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