

NOV 23 1938

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

36095
Do not use this space.

1. PLACE OF DEATH

(a) County Lacleade
(b) Township Lebanon
(c) City Lebanon

Registration District No. 449
Primary Registration District No. 4267

Registered No. _____

(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.

2. PRINT FULL NAME

Albert Sabath Agee
(a) Residence, No. 320 Hayes St St. ☐ (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Henrietta Agee
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 16 1870
7. AGE YEARS 68 MONTHS 7 DAYS 22 If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
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) Lacleade Co Mo

FATHER 13. NAME James Agee 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Rank, Kansas

MOTHER 15. MAIDEN NAME Anna Versorell 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lacleade Co

17. INFORMANT (ADDRESS) Map Agee
Lebanon Mo

18. BURIAL CREMATION OR REMOVAL PLACE New Hope DATE 10/9/38

19. FUNERAL DIRECTOR (ADDRESS) W. G. Holman
Lebanon Mo

20. FILED 10-13 1938 J. A. McCoull
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 8, 1938

22. I HEREBY CERTIFY, That I attended deceased from April 30, 1938 to Oct 1, 1938

I last saw him alive on Oct 1, 1938. Death is said to have occurred on the date stated above, at 1:50 a.m.
The principal cause of death and related causes of importance were as follows:

Sarcoma Right Arm
53

Other contributory causes of importance:

Generalized Metastasis.

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 Paul A. Jenkins M.D.
(Signed) Paul A. Jenkins M.D. M. D.
(Address) Lebanon, Mo.

RECEIVED

District Reg. No. (Office No.)

District File Number 7-38-376

Date Filed 11-10-38

STATEMENT BY LICENSED EMBALMER

I, Carl W. House, Licensed Embalmer No. 3955

hereby certify that the body recorded on the reverse side of this certificate was embalmed by myself

L. E.

No. or by Registered Apprentice No. working under my personal supervision.

Signed Carl W. House

Licensed Embalmer No. 3955

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.)