

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

18033  
Do not use this space.

1. PLACE OF DEATH <sup>(origin)</sup> JUN 4 1939  
 (a) County Buchanan Registration District No. 85  
 (b) Township Washington Primary Registration District No. 1001 Registered No. 472  
 (c) City St. Joseph (d) Street No. Mo. Methodist Hospital 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. 8 da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Thelbert Lemiul Cagle  
 (a) Residence, No. Savannah Mo. St.  Savannah, Mo.  
 (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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 10 1910

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
28 9 23

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Methodist  
 9. Industry or business in which work was done, as saw mill, bank, etc. Minisier  
 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) Rector Arkansas

FATHER 13. NAME Linial Cagle

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

MOTHER 15. MAIDEN NAME Ophelia Graves

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

17. INFORMANT Lucy Cagle  
 (ADDRESS) Savannah Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Savannah DATE May 5 1939

19. FUNERAL DIRECTOR (NAME) E. C. Breit  
 (ADDRESS) Savannah Mo.

20. FILED 574 1939 [Signature]  
 Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 3 1939

22. I HEREBY CERTIFY, That I attended deceased from April 25, 1939, to May 3, 1939  
 I last saw him alive on May 3, 1939. Death is said to have occurred on the date stated above, at 11: A.M.

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

Sub acute bacterial  
endo carditis  
(Staphylococci) no hemolytic  
Other contributory causes of importance:  
Chronic endo carditis  
partial inf. sufficiency  
Pneumonia

Name of operation ..... Date of .....  
 What test confirmed diagnosis? autopsy Was there an autopsy? yes

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? no  
 If so, specify .....  
 (Signed) [Signature], M. D.  
 (Address) 301 N. 8th St. Jackson, Mo.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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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**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, .....

E. C. Breit ....., or by .....

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

Signed E. C. Breit .....

Licensed Embalmer No. 2650 .....

P. O. Address Savannah Mo. .....

**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.**