

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

SOURCE: 1 X16035

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.

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

**32775**  
Do not use this space.

REC'D OCT 12 1939

1. PLACE OF DEATH *2*

(a) County Ladade Registration District No. 449

(b) Township Lebanon Primary Registration District No. 4267

(c) City Lebanon (d) Street No. \_\_\_\_\_ 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.

2. PRINT FULL NAME *28* Byron Agee

(a) Residence, No. \_\_\_\_\_ St.  (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 m 4. COLOR OR RACE w 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) Nov 7 1870

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>68</u>	<u>10</u>	<u>9</u>	

OCCUPATION

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. Carpenter

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) Ladade Co 0

FATHER

13. NAME Silas Agee 1

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark 0

MOTHER

15. MAIDEN NAME Mahla Agee

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

17. INFORMANT (NAME) Kaura Starnes  
(ADDRESS) Lebanon Mo

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Lebanon DATE 9/17/39 19

19. FUNERAL DIRECTOR (NAME) W. E. Halman  
(ADDRESS) Lebanon Mo

20. FILED 9-22-39 J. A. McComb  
Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9/16/39 19

22. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1939 to Sept 16, 1939

I last saw him alive on Sept 16, 1939 Death is said to have occurred on the date stated above, at 5 A m.

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

Chronic Sideral  
nephritis

Date of onset 1938

Other contributory causes of importance: 121

Name of operation None Date of \_\_\_\_\_

What test confirmed diagnosis? Purpura Was there an autopsy? No

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) P. J. ..., M. D.  
(Address) Lebanon Mo

RECEIVED

District Health Officer No. 7,

District File Number 7-39-1895-

Date Filed 10-9-39

**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 Myself

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed W.E. Holman

Licensed Embalmer No. 4107

P. O. Address Lebanon 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.**