

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

**33681**  
Do not use this space.

**1. PLACE OF DEATH**

(a) County Stoddard Registration District No. 838  
 (b) Township Liberty Primary Registration District No. 4509  
 (c) City Stoddard (d) Street No. \_\_\_\_\_ Registered No. \_\_\_\_\_ 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.

**2. PRINT FULL NAME**

Edith Lorene Hagy  
 (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**

**MEDICAL CERTIFICATE OF DEATH**

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 8, 1939

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

22. I HEREBY CERTIFY, That I attended deceased from Aug 5 - 1939 to Sept 8 - 1939

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 7, 1937

I last saw her alive on 9-7-1939 at 2 pm. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
2 3 1

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

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None  
 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 \_\_\_\_\_

General Septemur, 1939  
 Date of onset 101

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Stoddard Co., Mo.

Other contributory causes of importance: Abscess of Cervical Glands. Sept 5 - 1939

FATHER 13. NAME Carl F. Hagy

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Stoddard Co., Mo.

MOTHER 15. MAIDEN NAME Dora I. McFarlen

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Stoddard Co., Mo.

17. INFORMANT (ADDRESS) Carl F. Hagy  
Dexter, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE C. Dowdy Cem. DATE 9/9/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Blankenship-Strickland  
Dexter, Mo.

20. FILED 10/2 1939 Jennie Benton  
Local Registrar

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? e 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) S. S. Hensler, M. D.  
 (Address) Dexter Mo.

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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RECEIVED

District Health Officer No. 2,

District File Number 1039-260

Date Filed 10-11

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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.)

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