

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **37002**

Registration District No. **735**

Primary Registration District No. **30345970**

Registrar's No. **198**

1. PLACE OF DEATH:

(a) County **Randolph**  
(b) City or town **Rural Sugar Creek**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution (Specify whether)

In this community **Life**  
years, months or days

3. (a) PRINT FULL NAME **HALLIE MARIE AGEE**

8. (b) If veteran, name war: **—** 8. (c) Social Security No. **491-07-1607**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married divorced **Widowed**

6. (b) Name of husband or wife **G. L. Agee** 6. (c) Age of husband or wife if alive **Dead** years

7. Birth date of deceased **Jan. - 24 - 1896**  
(Month) (Day) (Year)

8. AGE: Years **43** Months **8** Days **25** If less than one day, hr. min.

9. Birthplace **Monroe Co. Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Laundry**

11. Industry or business **Halman Laundry**

12. Name **C. E. Rutledge**

13. Birthplace **Bloomfield Iowa**  
(City, town, or county) (State or foreign country)

14. Maiden name **Bertha Alice Riley**

15. Birthplace **Monroe Co. Mo.**  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **G. L. Agee**

(b) Address **RFD #4 Moberly Mo.**

17. (a) **Burial** (b) Date thereof **Oct-20-39**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Middle Grove Mo.**

18. (a) Signature of funeral director **Snout, Funeral Home**

(b) Address **Moberly Missouri**

19. (a) **Oct-20-39** (b) **Leah Williams**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Randolph**

(c) City or town **Rural**  
(If outside city or town limits, write "RURAL")

(d) Street No. **RFD #4 Moberly Mo.**  
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct-** day **18**  
year **1939** hour **Three** minute **—** A. M.

21. I hereby certify that I attended the deceased from **born to death**  
19 to 19

that I last saw him alive on and that death occurred on the date and hour stated above.

Immediate cause of death **Natural but not determined** Duration ?

Due to

Due to

Other conditions **Had anemia for several months**  
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature **D. J. Shrader** (M. D. or other) **Coroner**

Address **Moberly Mo.** Date signed **10-20-39**

RECEIVED

District Health Officer No. 10

District File Number 11-39-1944

Date Filed NOV 15 1939

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  
and R. M. Carter, Registered Apprentice No. 185,  
working under my personal supervision.

Signed Chas. G. Barnes

Licensed Embalmer No. 2414

P. O. Address Moberly 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.