

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1823

Registration District No. 91

Primary Registration District No. 5135

Registrar's No. 57

1. PLACE OF DEATH:
(a) County Butler
(b) City or town Hendrickson Rural
(c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Stafford B. Agee
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced Widower
6. (b) Name of husband or wife Mary 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov. 4, 1854
(Month) (Day) (Year)

8. AGE: Years 85 Months 1 Days 16 If less than one day _____ hr. _____ min.

9. Birthplace W. Va.
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER
12. Name Samuel Agee
13. Birthplace W. Va.
(City, town, or county) (State or foreign country)
14. Maiden name Polly
15. Birthplace W. Va.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature W. M. Harwell
(b) Address Hendrickson, Mo.

17. (a) Burial (b) Date thereof Dec. 22, 1939
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Three Springs Cem.

18. (a) Signature of funeral director Greer-Croy Service
(b) Address Poplar Bluff, Mo.

19. (a) Dec 24/34 (b) W. C. Gilman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Butler
(c) City or town Hendrickson, Mo. Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 20
year 1939 hour 3 minute 0 M.

21. I hereby certify that I attended the deceased from Dec 20, 1939 to Dec 20, 1939
that I last saw him alive on Dec 10, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy Duration 1 day
Due to senility
Arteriosclerosis

Other conditions _____
(Include pregnancy within 3 months of death) \$70

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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? _____

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

23. Signature J. Harwell (M. D. or other) _____
Address Poplar Bluff, Mo. signed 12/24/39

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.....
....., 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.