

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

4123
Do not use this space.

FILED FEB 15 1940

1. PLACE OF DEATH

(a) County Vernon 3 Registration District No. 875
 (b) Township Washington 0 Primary Registration District No. 6162 Registered No. 14
 (c) City Alexandria (d) Street No. State Hospital # 3 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 2 yrs. 10 mos. 18 da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

Charles Agnew
 (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 Male 4. COLOR OR RACE White 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) Oct. 19, 1876

7. AGE YEARS MONTHS DAYS If LESS than 1 day, = hrs. or = min.
63 3 1

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Packer
 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 _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

FATHER 13. NAME James Agnew

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

MOTHER 15. MAIDEN NAME Julia Wrightman

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) West Virginia

17. INFORMANT (ADDRESS) Records, State Hospital #3

18. BURIAL, CREMATION, OR REMOVAL PLACE Shoop Cemetery DATE Jan 23 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Shoop Funeral Soc. Nevada, Mo

20. FILED Jan 23 1940 Allen V. Day Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 20, 1940

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw h..... alive on _____, 19____. Death is said to have occurred on the date stated above, at 12³⁰ p.m.
 The principal cause of death and related causes of importance were as follows:

Tobacco poisoning
Type unknown
 Date of onset 12/1

Other contributory causes of importance:
obscure prostatic
with urinary retention
 Name of operation Cystostomy Date of 1/15/40
 What test confirmed diagnosis? _____ 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?
 If so, specify _____

(Signed) Allen V. Day M. D.
 (Address) State Hospital Nevada, 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.

RECEIVED

District Health Officer No. 7,

District File Number 2-40-283

Date Filed 2-14-40

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 Allen V. Hays

Licensed Embalmer No. 19068

P. O. Address Nevada, 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.