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DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31308**

DATE OF DEATH
FILLED OCT 16 1941

Registration District No. **152**

Primary Registration District No. **5216**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Cass**
(b) City or town **East Lynne, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(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)

8. (a) PRINT FULL NAME **MELVIN S. KAGRICE**

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 **W 2**

6. (b) Name of husband or wife **William C Kagrice** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **May 10 1868**
(Month) (Day) (Year)

8. AGE: Years **73** Months **3** Days **3** If less than one day _____ hr. _____ min.

9. Birthplace **Louisville, Ky.**
(City, town, or county) (State or foreign country)

10. Usual occupation **House wife**

11. Industry or business _____

MOTHER FATHER { 12. Name **Abraham Feilack**
13. Birthplace **Ky.**
(City, town, or county) (State or foreign country)
14. Maiden name **Sallie Fuller**
15. Birthplace **Ky.**
(City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Aug. 15 1941**
(Month) (Day) (Year)
(c) Place: burial or cremation **Pitts Chapel**

18. (a) Signature of funeral director **A. D. Naylor**
(b) Address **East Lynne, Mo.**

19. (a) **Oct. 9, 1941** (Date received local registrar) (b) **Effie Stoner** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Cass 19**
(c) City or town **East Lynne**
(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 **Aug** day **13**
year **1941** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) **7:30!**

Major findings: Of operations _____
Of autopsy _____

Duration _____
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? _____

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

23. Signature **J. H. Smith** (M. D. or other)
Address **Harrisonville, Mo.** Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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..... *A. W. Hartley*

Licensed Embalmer No. *2717*

P. O. Address *East Lyme, Vt.*

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.