

FILED SEP 16 1943
Registration District No. 275

Primary Registration District No. 6280

1. PLACE OF DEATH:

(a) County. **Wright**
(b) City or town. **Norwood Rural Hart**
(c) Name of hospital or institution: **Home of her daughter 7 miles northwest of Norwood**
(If outside city or town limits, write "RURAL" and name of township)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. **None**
In this community. **87 yrs.**
(Specify whether years, months or days)

8. (a) PRINT **SARAH TRIPHENA AGEE**
FULL NAME8. (b) If veteran, name war. **None**
8. (c) Social Security No. **None**

4. Sex **F.** 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive, years

7. Birth date of deceased **2 27 1856**
(Month) (Day) (Year)8. AGE: Years **87** Months **4** Days **27** If less than one day hr. min.9. Birthplace **Wright Co. Mo.**
(City, town, or county) (State or foreign country)10. Usual occupation **House Wife**

11. Industry or business

12. Name **Issac Hart**
13. Birthplace **Unknown**
14. Maiden name **Triphena Pool**
15. Birthplace **Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature

(b) Address **Burial**
17. (a) (Burial, cremation, or removal) (b) Date thereof **7 25 43**
(Month) (Day) (Year)

(c) Place: burial or cremation **Wynn Cem.**18. (a) Signature of funeral director **Gene E. Halden**(b) Address **Hartsville, Mo.**

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Norwood 114**
(c) City or town **Norwood Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **7 miles north west of Norwood**
(If rural, give location)
(e) If foreign born, how long in U. S. A. **0** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **7** day **24**
year **1943** hour **2:00** minute **35 P.M.**21. I hereby certify that I attended the deceased from **7/24** to **7/24**, 19**43**,
that I last saw him alive on **7/24**, 19**43**,
and that death occurred on the date and hour stated above.Immediate cause of death **myocardial infarction**
Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **92 lb**

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 **0**23. Signature **W. W. Vaghey** (M. D. or other)Address **Norwood** Date signed

RECEIVED
District Health Officer No. 61
District File Number 943-1109
Date Filed 9-15-43

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

Gene E. Holden

Licensed Embalmer No.

3865

P. O. Address

Wartville, 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *out*

Registration District No. *375*

Primary Registration District No. *6286*

Registrar's No. *27*

1. PLACE OF DEATH:

(a) County *Wright*
(b) City or town *Rural*
(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 years, months or days)

3. (a) PRINT FULL NAME *Sarah Triphena Agee*

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex *F* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *W*

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

7. Birth date of deceased *Feb 27 1886*
(Month) (Day) (Year)

8. AGE: Years *87* Months *4* Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant *Kone given*

(b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) *18-3-43* (b) *W. J. Wynn*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year *1943* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

Other conditions. (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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

PHYSICIAN

Underline the cause to which death should be charged statistically.

32843