

Registration District No. **118**

Primary Registration District No. **5440**

Registrar's No. **105**

1. PLACE OF DEATH: **Gassonade**
 (a) County **Gassonade**
 (b) City or town **Clayton - Bland**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **none**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **1**
 (Specify whether years, months or days) **25 yrs**

2. USUAL RESIDENCE OF DECEASED: **37**
 (a) State **Mo** (b) County **Gassonade**
 (c) City or town **Bland**
 (If outside city or town limits, write "RURAL") **Rural**
 (d) Street No. **Rural**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? **0** years

3. (a) PRINT FULL NAME **Emma Rilla Stagg**
 (b) If veteran, name war **✓**
 (c) Social Security No. **none**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **11** day **11**
 year **1944** hour **4** minute **30 P** M.
 21. I hereby certify that I attended the deceased from **11-11-44**
 19 **43** to **11-11-44** 19 **44**
 that I last saw h. **alive** on **11-5-44** 19 **44**
 and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color or race **W.**
 6. (a) Single, widowed, married, divorced **2**
 (b) Name of husband or wife **Wm Stagg** Age of husband or wife if alive **✓** years
 7. Birth date of deceased **June 28 - 1864**
 (Month) (Day) (Year)

Immediate cause of death **Endo-carditis**
 Due to **Bronchitis**

8. AGE: Years **80** Months **4** Days **16**
 If less than one day hr. min.

Due to **Bronchitis**
 Other conditions (include pregnancy within 3 months of death)
 Major findings: Of operations **92**
 Of autopsy

9. Birthplace **Lanes Prairie Mo**
 (City, town, or county) (State or foreign country)
 10. Usual occupation **Housework**

MOTHER FATHER
 11. Industry or business
 12. Name **John Reed**
 13. Birthplace **not known**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Sarah Jones**
 15. Birthplace **not known**
 (City, town, or county) (State or foreign country)

PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant **Mrs. F. N. Nohens**
 (b) Address **Bland Mo**
 17. (a) **burial** (b) Date thereof **11-18-44**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Union Cem**
 18. (a) Signature of funeral director **Gassmann Funeral Home**
 (b) Address **Bland Mo**
 19. (a) **Nov 16, 1944** (b) **Myrtle M. Wenkel**
 (Date received local registrar) (Registrar's signature)

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) (e) Means of injury **✓**
 23. Signature **P. H. Buzge** (M. D. or other)
 Address **Bland Mo** Date signed **11-17-44**

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 12-6-44

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. me

working under my personal supervision.

Signed Robert M Murray

Licensed Embalmer No. 3749

P. O. Address Owensville,

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, fact should be so stated above.