S. No. 2
M—8-43
. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 10 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13740

Registration District No. 170 Primary Registration District No. 3033 Registrar's No.

1. PLACE OF DEATH:

(a) County LACLEDE
(b) City or town LEBANON
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
904 N ADAMS
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution — (Specify whether
In this community 2 WKS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County LACLEDE
(c) City or town LEBANON
(If outside city or town limits, write "RURAL")
(d) Street No. R 3
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Thos. B. AGAN
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife LIZA MEYERS
6. (c) Age of husband or wife if alive 74 years
7. Birth date of deceased SEPT (Month) 7 (Day) - 1860 (Year)

8. AGE:	Years	Months	Days	If less than one day
	84	7	12	hr. min.

9. Birthplace WILLENE (City, town, or county) IND 1 (State or foreign country)
10. Usual occupation FARMER
11. Industry or business
FATHER
12. Name HENRY AGAN
13. Birthplace (City, town, or county) IND. 1 (State or foreign country)
MOTHER
14. Maiden name MARTHA HARNARD
15. Birthplace (City, town, or county) IND. 1 (State or foreign country)
16. (a) Informant S. C. Agan
(b) Address LEBANON MO
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof APR (Month) 22 (Day) 45 (Year)
(c) Place: burial or cremation LEBANON Mo.
18. (a) Signature of funeral director Palmers
(b) Address LEBANON
19. (a) May 1 45 (Date received local registrar) (b) Grace Roper (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APR day 19
year 1945 hour 10 minute 15 P.M.
21. I hereby certify that I attended the deceased from March 27, 1945, to April 19th, 1945;
that I last saw him alive on April 18th, 1945;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cardiac Failure	
Due to	
Due to Myocarditis (Chronic)	
Other conditions (Include pregnancy within 3 months of death)	
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 R. G. Saunders (M. D. or other) D.O.
Address Lebanon, Mo. Date signed 4/25/45

1670 (Licensed Embalmer's Statement on Reverse Side)

Received .....
Laclede County Health Unit
File No. 4-45-49
Date Filed 5/8/45

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 D. A. Palmer

Licensed Embalmer No. 1161

P. O. Address Lebanon

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.