. S. No. 2
00M—5-43
ev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED SEP 1 1945

State File No. 26435

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3449

1. PLACE OF DEATH:

(a) County JACKSON

(b) City or town KANSAS CITY
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1016 FOREST AVENUE
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution — (Specify whether
In this community 25 YRS years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON 48

(c) City or town KANSAS CITY 3
(If outside city or town limits, write "RURAL")

(d) Street No. 1016 FOREST AVENUE 8
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 11

If yes, name country

3. (a) PRINT FULL NAME HENRY A. HAGOOD

3. (b) If veteran, name war WORLD WAR I

3. (c) Social Security No. 486-09-8120

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife — VINNIE A. HAGOOD

6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased JANURRY (Month) 5 (Day) 1890 (Year)

8. AGE: Years 55 Months 7 Days 10 If less than one day ___ hr. ___ min.

9. Birthplace DONIPHAN (City, town, or county) MISSOURI (State or foreign country)

10. Usual occupation BARBER

11. Industry or business ~~DEE WITT HAGOOD~~

FATHER
12. Name DEE WITT HAGOOD
13. Birthplace UNKNOWN (City, town, or county) ILLINOIS (State or foreign country)

MOTHER
14. Maiden name DELLA TOWELL
15. Birthplace UNKNOWN (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Vinnie A Hagood
(b) Address 1016 Forest Avenue

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof AUG 17 1945 (Month) (Day) (Year)
(c) Place: burial or cremation HOXIE, ARKANSAS

18. (a) Signature of funeral director D. W. Newcomer's Sons
(b) Address 1401 Brush Creek Blvd

19. (a) 8-17-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUGUST day 15 year 1945 hour 3 minute 20 P. M.

21. I hereby certify that I attended the deceased from Aug-11- 1945 to Aug. 15 1945 that I last saw him alive on Aug 15 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Thrombosis	5 days
Due to Arteriosclerosis	4 yrs
Glomerular nephritis	
Due to vascular disease	4 yrs
Other conditions (Include pregnancy within 3 months of death)	

94a

Major findings:
Of operations none
Of autopsy none

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 Allen L. Hearst (M. D. ~~or other~~)
Address 1100 Prof. Bldg. Date signed Aug 16 1945

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(Licensed Embalmer's Statement on Reverse Side)

SEP 6 1948

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. E. Oscar Northey

Licensed Embalmer No. 1767

P. O. Address. Kansas City

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.