

U.S. No. 2  
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Rev. 5-17-39  
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THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **34102**

**FILED NOV 6 1946**

Registration District No. **187**

Primary Registration District No. **3090**

Registrar's No. **121**

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

19  
1  
2

1. PLACE OF DEATH:

(a) County Lickingston

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

(c) Name of hospital or institution:  
409-Polk 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 45-years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lickingston **59**

(c) City or town Chillicothe **1**  
(If outside city or town limits, write "RURAL")

(d) Street No. 409-Polk **21**  
(If rural, give location) **0**

(e) Citizen of foreign country? No. (Yes or No) **0**

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME John Calvin Jagger

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 18  
year 1946 hour 10 minute P-M.

21. I hereby certify that I attended the deceased from 10:15 AM to 1:15 AM, 1946  
that I last saw him alive on 18 Oct, 1946  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Mary Elizabeth

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

7. Birth date of deceased March 29-1866  
(Month) (Day) (Year)

Immediate cause of death Myocardial Emphysema

Duration \_\_\_\_\_

8. AGE: Years 80 Months 6 Days 19  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

9. Birthplace Fairfield Iowa  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer - Retired

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

MOTHER FATHER

11. Industry or business \_\_\_\_\_

12. Name Frank Jagger

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

14. Maiden name Sarah Mc Murry

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Jay Kester

(b) Address Chillicothe Mo.

17. (a) Burial (b) Date thereof 10-20-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hale, Mo.

18. (a) Signature of funeral director Donald Gordon

(b) Address Chillicothe Mo.

19. (a) Oct-18-46 (b) Francis B. Neel  
(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) no

(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 V D Vandusen (M.D. or other) **0**

Address Chillicothe Mo Date signed 19 Oct 46

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NOV 6 1948

DISTRICT HEALTH OFFICE  
Cameron, Mo.  
DISTRICT HEALTH OFFICE  
Cameron, Mo.

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 Wayne Rollins  
Licensed Embalmer No. 1144  
P. O. Address Chillicothe

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.