

FILED NOV 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36590

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>59</u>		PRIMARY REG. DIST. NO. <u>4098</u>		Registrar's No. <u>175</u>		
1. PLACE OF DEATH a. COUNTY <u>Cass</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Cass</u>				
b. CITY (If outside corporate limits, write RURAL and give township) <u>Belton</u> /		c. LENGTH OF STAY (in this place) <u>2 1/2 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Belton</u>		19 0 0 0		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Cedar and 2nd, Sts.</u>				d. STREET ADDRESS (If rural, give location) <u>Cedar and 2nd Sts.</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Clarence</u> b. (Middle) <u>Elbert</u> c. (Last) <u>Bagshaw</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 10, 1949</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Apr. 24, 1875</u>		
9. AGE (In years last birthday) <u>74</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 4 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Watch maker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Jewelry Store</u>		11. BIRTHPLACE (State or foreign country) <u>Pekin, Indiana</u> /		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Theodore Bagshaw</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Thomas</u>		14. NAME OF HUSBAND OR WIFE <u>Sarah Addie Bagshaw</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. C. E. Bagshaw Belton, Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 331X					INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <u>Nov 3, 1949</u> , to <u>Nov 10, 1949</u> , that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>R. M. McKee, M.D.</u>				23b. ADDRESS <u>Belton Mo</u>		23c. DATE SIGNED <u>11/13/49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Nov. 13, '49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery,</u>		24d. LOCATION (City, town, or county) (State) <u>Harrisonville, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>Nov. 14, 1949</u>		REGISTRAR'S SIGNATURE <u>Laura J. Jones</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E. K. George & Sons</u>		ADDRESS <u>Belton Mo</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed A. F. George

Licensed Embalmer No. 3645

P. O. Address Landover, Md.

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.