

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7424

State File No. _____

Registrar's No. 197

FILED MAR 17 1955

BIRTH NO. _____ REG. DIST. NO. 43 PRIMARY REG. DIST. NO. 5141

1. PLACE OF DEATH a. COUNTY <u>BUTLER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO.</u> b. COUNTY <u>BUTLER</u>	
b. CITY OR TOWN <u>FAGUS</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>FAGUS</u> <u>012B</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION.		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Ollie</u> b. (Middle) <u>BAGWELL</u> c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>3-11-55</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Feb. 11, 1888</u>	9. AGE (In years last birthday) <u>67</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 12 HRS. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House WIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MO.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>UNKNOWN</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>Alex Bagwell</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>ANNA KOWENS</u> ADDRESS <u>FAGUS MO.</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u>		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 3-9 1955 to 3-11 1955, that I last saw the deceased alive on 3-10 1955 and that death occurred at 3:52 m., from the causes and on the date stated above.

23a. SIGNATURE <u>T. H. Jones M.D.</u> (Degree or title)	23b. ADDRESS <u>Highway 20</u>	23c. DATE SIGNED <u>3-12-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>3-13-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Ston Field Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>CLARKTON MO</u>
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DATE REC'D BY LOCAL REG. <u>3/12/55</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Lloyd Russell</u> ADDRESS <u>[Address]</u>
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No. 300
10-48

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

RECEIVED
MAR 14 1955

BUTLER CO. HEALTH CENTER

FILE No. _____

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 Leroy J. Tyler

Licensed Embalmer No. 4941 MD.

P. O. Address Piquette Ave.

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.