Health, Welfare Public Service

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

41027 STATE FILE NUMBER

FILED NOV 25 1957

Registration District No. 179 Primary Registration District No. 5667 Registrar's No. 34

300 11-57 057 0

1. PLACE OF DEATH
a. COUNTY: Lincoln
b. CITY OR TOWN: Bedford Twp. — Inside Limits: Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION: Lincoln County Hosp. — Length of stay in 1b:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: LINCOLN
c. CITY OR TOWN: Troy — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): Box 203-Rt. 1 — Resided on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: STEVE(STEPHEN) Middle: (AGVIAN) Last: AGOAIN

4. DATE OF DEATH: Month: Nov. Day: 11 Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 15, 1887

9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Candy Maker (Retired) Proprietor

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): Armenia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: Unknown Agoain

13b. MOTHER'S MAIDEN NAME: Unknown

14. NAME OF HUSBAND OR WIFE: Mae Agoain

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Yes World War I

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Mae Agoain-Box 203-Rt.1-Troy, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral Vascular Hemmhage — INTERVAL BETWEEN ONSET AND DEATH: 10 Days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Arter-Sclerosis

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 331X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 2/4/55 to 11/11 and last saw her/him alive on 11/11/57

Death occurred at 6:00 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): J. Cassch MD

22b. ADDRESS: Troy Mo

22c. DATE SIGNED: 11/25/57

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal(Mtr) **23b. DATE:** 11-15-1957

23c. NAME OF CEMETERY OR CREMATORY: Oak Grove Cemetery

23d. LOCATION (City, town, or county) (State): St. Louis Co. Mo.

24. FUNERAL DIRECTOR: Kriegshauser **ADDRESS:** 4228 S. Kingshighway

25. DATE RECD. BY LOCAL REG.: NOV 22 1957

26. REGISTRAR'S SIGNATURE: Nell-S. Schuenhein

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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NOV 26 1957 DEC 9 1957

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 ..... Signed William C. White

Signature of Student Embalmer

Licensed Embalmer No. [illegible]

P. O. Address [illegible]

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.