

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014398
STATE FILE NUMBER

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 51

1. PLACE OF DEATH a. COUNTY <u>PIKE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LOUISIANA</u>		c. CITY OR TOWN <u>ST. LOUIS, 12</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
4 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>LOUISIANA NURSING HOME</u>		d. STREET ADDRESS <u>5387 Page Blvd.</u>	
Length of stay in lb <u>206</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MILDRED JANE BAGLEY</u>			4. DATE OF DEATH Month Day Year <u>APRIL 13, 1959</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/17/1873</u>
9. AGE (In years last birthday) <u>86</u>		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) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (City and state or country) <u>SALDISA, KY.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>ANDREW JACKSON SPRINGATE</u>	
13b. MOTHER'S MAIDEN NAME <u>MILDRED JANE BROWN</u>		14. NAME OF HUSBAND OR WIFE <u>FRANK ALBERT BAGLEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, war or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>498-03-7309D</u>	
17. INFORMANT <u>Alexander Funeral Home, St. Louis, Mo.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer</u>			INTERVAL BETWEEN ONSET AND DEATH <u>about 6 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>none</u>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <u>Feb 14, 1959</u> to <u>April 1</u> and last saw her alive on <u>April 1, 1959</u> Death occurred at <u>1:30 PM April 13, 1959</u> of the date stated above; and to the best of my knowledge from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Dr. Samuel G. Scanzio DC</u>		22b. ADDRESS <u>Louisiana, Mo.</u>	
22c. DATE SIGNED <u>4/13/59</u>			
23a. BURIAL, CREMATION, REMOVAL <u>REMOVAL</u>		23b. DATE <u>APRIL 13, 1959</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Springfield Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Harrodsburg, Kentucky</u>	
24. FUNERAL DIRECTOR <u>ALEXANDER & SONS, 6175 DELMAR BLVD</u>		25. DATE RECD. BY LOCAL REG. <u>April 13, 1959</u>	
ADDRESS <u>ST. LOUIS, MO</u>		26. REGISTRAR'S SIGNATURE <u>Bernice Collier</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300
1-57

All diseases in Part I must be causally related.

VS APR 21 1956

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
Signature of Student Embalmer

Signed *George O. Hagner*

Licensed Embalmer No. *3773*
P. O. Address *Louisiana*

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.