

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-020373 STATE FILE NUMBER

AMENDED FILED Registration District No. 37 Primary Registration District No. 4049 Registrar's No. 27

1. PLACE OF DEATH a. COUNTY Boone		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Boone	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Centralia		Length of stay in 1b 20 days	c. CITY OR TOWN Centralia Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Campbell Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 415 South Allen Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Ute Middle Fynis Last Fagg			4. DATE OF DEATH Month June Day 14 Year 1961		
5. SEX Male	6. COLOR OR RACE Caucasian	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Mar 24, 1879	9. AGE (last birthday) 82	IF UNDER 1 YEAR Months 2 Days 20 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) Hinton, Missouri	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME James Thomas Fagg		13b. MOTHER'S MAIDEN NAME Dorcas Lawson		14. NAME OF HUSBAND OR WIFE Gussie Wilson Fagg	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Address Mrs. Harold Cox Centralia, 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) acute coronary occlusion arteriosclerotic and hypertensive cardiovascular disease with chronic heart failure and uremia DUE TO (b) acute coronary occlusion DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH acutely five years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	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 <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 **9-13-55** to **6-10-61** and last saw her/him alive on **6-10-61**
Death occurred at **approximately 5:50 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deceased or title) Robt L Ward, M.D.	22b. ADDRESS Centralia, Missouri	22c. DATE SIGNED 6-15-61
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 17, 1961	23c. NAME OF CEMETERY OR CREMATORY City of Centralia
23d. LOCATION (City, town, or county) Centralia, Missouri		23e. STATE Missouri

24. FUNERAL DIRECTOR Wm J Meador	ADDRESS Centralia, Mo.	25. DATE RECD. BY LOCAL REG. June 17-1961	26. REGISTRAR'S SIGNATURE Maud M^{rs} Bride
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

JUN 20 1961

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 Bill J. Meador

Licensed Embalmer No. 4876

P. O. Address Centralia, Mo

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.