

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-012363

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 82

DO NOT WRITE ON THIS STUB
 AMENDED

VS 300
 Rev. 4/59

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30595

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFRUIT OF

FILED APR 1 1963		1. PLACE OF DEATH a. COUNTY LIVINGSTON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY LIVINGSTON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN CHILLICOTHE		Length of stay in 1b 1 YEAR		c. CITY OR TOWN CHILLICOTHE Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1103 JACKSON ST.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1103 JACKSON ST. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last SOPHRONIA ELIZABETH BAGBEY			4. DATE OF DEATH Month Day Year MARCH 25 1963		
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	
8. DATE OF BIRTH 11/30/66		9. AGE (last birthday) 96		IF UNDER 1 YEAR IF UNDER 24 HR. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME MAKER		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (City and state or country) FREDERICKTOWN, MO.	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME JAMES M. REVELLE		13b. MOTHER'S MAIDEN NAME EVA JANE DeSHAY	
14. NAME OF HUSBAND OR WIFE CHARLES EDWIN BAGBEY		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. J.P. MORGAN	
17. INFORMANT 1713 Calhoun St. CHILLICOTHE, MISSOURI		18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Terminal 1 day DUE TO (b) Mitral Stenosis Severe 25 years DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
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 checked="" 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.		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 <u>Jan. 15-63</u> to <u>Mar 25-63</u> and last saw her <u>Mar 23-63</u> alive on <u>Mar 23-63</u> Death occurred at <u>6:30</u> P.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Joseph P. Conrad M.D.</i>		(Degree or title)		22b. ADDRESS <i>Chillicothe, Mo.</i>	
22c. DATE SIGNED <i>Mar 26-63</i>		22d. DATE SIGNED (State)			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3-29-63		23c. NAME OF CEMETERY OR CREMATORY DONGOLA CEMETERY	
23d. LOCATION (City, town, or county) STODDARD CO., MISSOURI		24. FUNERAL DIRECTOR NORMAN FUNERAL HOME: Chillicothe, Mo.			
25. DATE RECD. BY LOCAL REG. March 26, 1963		26. REGISTRAR'S SIGNATURE <i>Annalu Taylor</i>			

USE BLACK INK OR TYPEWRITER RIBBON

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1000

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TAKEN TO Dr. C. C. C. 26 MAR 63
Rec'd from Dr. C. C. C. 26 MAR 63

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 Elton Norman

Licensed Embalmer No. 4036

P. O. Address CHILLICOTHE, MISSOURI

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.