

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **22871**

Registration District No. **784**

Primary Registration District No. **112**

Registrar's No. **1089**

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Rock Hill Village
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community 40 years
years, months or days)

3. (a) PRINT FULL NAME Sarah Jane Bagent
3. (b) If veteran, name war. No
3. (c) Social Security No. No

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Henry W.
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased. Sept 13 1856
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
83 8 24 hr. min.

9. Birthplace Pittsfield Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Self

MOTHER FATHER
12. Name Thimoth Girton
13. Birthplace ? Ohio
(City, town, or county) (State or foreign country)
14. Maiden name LUCY Curless
15. Birthplace ? Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Ms Louis Good
(b) Address Warson Rd. Rock Hill Village

17. (a) Removal (b) Date thereof June 10, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pittsfield Illinois

18. (a) Signature of funeral director A.W. McLaughlin
(b) Address 2301 Lafayette Ave

19. (a) JUN 8 - 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town Rock Hill Village
(If outside city or town limits, write "RURAL")
(d) Street No. Warson Road
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 7
year 1940 hour 3 minute 20 P. M.
21. I hereby certify that I attended the deceased from 11-19-38
June 1938 to June 7 1940
that I last saw her alive on June 7 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Senility
Duration 7 yrs

Due to Intra Cerebral Fract L. Temp.
Due to Fall from home 26 days

Other conditions Atherosclerosis
(Include pregnancy within 3 months of death)

Major findings: Hypertension
operations none
Of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following.

(a) Contribution
(b) Date of occurrence May 11 - 40
(c) Where did injury occur? Home
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home
While at work no (Specify type of place) (e) Means of injury

23. Signature R.E. Gaston (M. D. or other)
Address Webster Groves, Mo. Date signed 6/8/40

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *L. R. Casper*.....

Licensed Embalmer No. *3633*

P. O. Address *2317 Lafayette*

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, above space should be left blank.

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