

FILED AUG 28 1942

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

## 1. PLACE OF DEATH

(a) County Oregon Registration District No. 686 75  
 (b) Township Piney Primary Registration District No. 5844  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ Registered No. 21  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Susan Sophronia Cagle

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 4, 1861  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
81 1 24

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Domestic  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown13. NAME Wm. DePriest14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown15. MAIDEN NAME Unknown16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown17. INFORMANT (ADDRESS) C. Z. Cagle  
Alton, Mo.18. BURIAL, CREMATION, OR REMOVAL  
PLACE Cave Springs DATE 4/29/4219. FUNERAL DIRECTOR (NAME) (ADDRESS) Red Oak Home  
Pharos, Mo.20. FILED 3/6 42 Tracy Williams  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 28, 1942

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

I last saw him alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 3:45 a. M.

The principal cause of death and related causes of importance were as follows:

General Hemorrhage  
Hypertensive Heart  
Disease with General  
Atherosclerosis

Date of onset

Other contributory causes of importance:

Smoking 820

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?

If so, specify \_\_\_\_\_, M. D.

(Signed) Dr. J. H. Cooper(Address) Pharos, Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

MARGIN RESERVED FOR BINDING

50M-9-19-38 I X16605

RECEIVED

District no. \_\_\_\_\_ cer no

District File Number 742621

Date Filed 8-19-42

S-18637

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**