

FILED JAN 1 1945

Registration District No. **12**

Primary Registration District No. **1000**

Registrar's No. **1317**

1. PLACE OF DEATH:
(a) County **Richmond**
(b) City or town **St Joseph Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **State Hospital # 2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 yrs 11 mos 17 da**
(Specify whether years, months or days)
In this community **Yes**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **De Kalb**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Mary E. Bagby**
(b) If veteran, name war _____ (c) Social Security No. **nil**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **12/3** day **10** year **1944** hour **40** minute **0** M.

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced, widower
(b) Name of husband or wife **deceased** (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **12 Jan 22 1874**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Jan 1st 1944** to **12/3 1944**
and that I last saw him alive on **12/3 1944**
and that death occurred on the date and hour stated above.
Immediate cause of death **Complete blockage of the aortic aorta probably due to hypernephrosis of the suprarenals**
Due to **Quadrantal ulcers several years ago**
Due to **Don't know**

8. AGE:	Years	Months	Days	If less than one day
	70	11	21	hr. _____ min. _____

Other conditions **Fracture of hip about 1 month (includes pregnancy within 6 months of death)**
Major findings: **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**
Of operations _____
Of autopsy **Autopsy requested**

9. Birthplace **De Kalb County Mo**
(City, town, or county) (State or foreign country)
10. Usual occupation **House wife**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place)
(e) Means of injury _____

MOTHER FATHER
11. Industry or business **at home**
12. Name **Hellmuth Turnage**
13. Birthplace **Ray County Mo**
(City, town, or county) (State or foreign country)
14. Maiden name **Elizabeth Turnage**
15. Birthplace **De Kalb County Mo**
(City, town, or county) (State or foreign country)

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

16. (a) Informant **C. E. Estes**
(b) Address **Fairport Mo**

17. (a) **Burial** (b) Date thereof **12-15-44**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Fairport Mo**
18. (a) Signature of funeral director _____
(b) Address **Mayfield Mo**
19. (a) **12-15-44** (b) **Edwin J. Tisdale**
(Date received local registrar) (Registrar's signature)

23. Signature **C. E. Estes** (M. D. or other)
Address **State Hospital # 2** Date signed **12/13 1944**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1377

FEB 1 1945

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.....

John B. Brown
.....
Licensed Embalmer No. 3933

P. O. Address *Mayfield*

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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40621

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Buchanan
 (b) City or town Joseph, Mo.
(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 _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County _____
 (c) City or town _____
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Mary E. Bagby
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April year 1944 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____;
 that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

4. Sex F **5. Color or race** W
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years

Duration
 Due to Probably a duodenal ulcer Don't know

7. Birth date of deceased Jan 22 1878
(Month) (Day) (Year)
8. AGE: Years 70 Months 11 Days _____
If less than one day hr. min.

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

9. Birthplace _____
(City, town, or county) (State or foreign country)
10. Usual occupation _____
11. Industry or business _____
MOTHER { **12. Name** _____
13. Birthplace _____
(City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____
(City, town, or county) (State or foreign country)

PHYSICIAN
Major findings: _____
 Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant _____
(b) Address _____
17. (a) _____ **(b) Date thereof** _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____
(b) Address _____
19. (a) _____ **(b)** _____
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
 While at work? _____
 Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTAL

1944

S-40621