

STANDARD CERTIFICATE OF DEATH

State File No. 38279

Registration District No. 2946294

Primary Registration District No. 2943056

Registrar's No. 185

1. PLACE OF DEATH:

(a) County Bartholomew  
(b) City or town Monticello  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: McConnell Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day (Specify whether  
In this community \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Chariton  
(c) City or town Rural (If outside city or town limits, write "RURAL")  
(d) Street No. Doubling Sup. 7 miles S. E. of Mt. Vernon (If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME VIRGIE-KATIE-AGEE.

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex Female 5. Color or race Black 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Floyd Agge 6. (c) Age of husband or wife if alive 64 years  
7. Birth date of deceased April 14 - 1884 (Month) (Day) (Year)

8. AGE: Years 61 Months 8 Days 6 If less than one day hr. min.

9. Birthplace Dalton Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Richard Dalton

12. Name Richard Allen

13. Birthplace Dalton Mo. (City, town, or county) (State or foreign country)

14. Maiden name Beth Murch

15. Birthplace Dalton Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Floyd Agge

(b) Address Dalton Mo.

17. (a) Burial (b) Date thereof Oct 10 - 1945 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dalton

18. (a) Signature of funeral director W. H. McConick

(b) Address 300 1/2 Reed St. Mt. Vernon, Mo.

19. (a) 10-10-45 (b) Leah Williams (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 8 year 1945 hour 1 minute 30.9 M.

21. I hereby certify that I attended the deceased from 10-7 1945 to 10-7 1945; that I last saw her alive on 10-7-45 and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal obstruction Duration 8 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

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 \_\_\_\_\_

23. Signature W. H. McConick O.O. (M.D. or other) \_\_\_\_\_

Address 300 1/2 Reed St. Mt. Vernon, Mo. Date signed 10-12-45

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

MOTHER FATHER

1601

(Licensed Embalmer's Statement on Reverse Side)

DEC 13 1945

RECEIVED

District Health Officer No. 10

District File Number 17-45-1659

Date Filed NOV 23 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 N. D. Barnett

Licensed Embalmer No. 3046

P. O. Address Keytesville

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.

Registration District No. 294

Primary Registration District No. 3056

Registrar's No. 185

**1. PLACE OF DEATH:**  
 (a) County Randolph  
 (b) City or town Madely  
(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)

**3. (a) PRINT FULL NAME** Virgie K. Agee  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

4. Sex J  
 5. Color or race B  
 6. (a) Single, widowed, married, divorced m  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Apr 4 1887  
(Month) (Day) (Year)

8. AGE: Years 61 Months \_\_\_\_\_ Days \_\_\_\_\_  
(If less than one day)  
 hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
 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)

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)

**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 \_\_\_\_\_

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month Dec  
 year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M. \_\_\_\_\_  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death Intestinal obstruction Duration \_\_\_\_\_

Due to C.A. of sigmoid

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy 468

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

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?  
 \_\_\_\_\_  
(Specify type of place)  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

38279