

S. No. 2  
M-2-43  
5-7-39  
X 35897

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

**FILED JUN 12 1946** STANDARD CERTIFICATE OF DEATH

State File No. **17383**

Registration District No. **209**

Primary Registration District No. **3043**

Registrar's No. **174**

**1. PLACE OF DEATH:**

(a) County Marion  
(b) City or town Linnical  
(c) Name of hospital or institution:  
117 1/2 South Main St.  
(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 Missouri (b) County Marion **64**  
(c) City or town Linnical **2**  
(If outside city or town limits, write "RURAL")  
(d) Street No. 316 South 5th St. **4**  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME.** Adrian C. Pagon

3. (b) If veteran, name war World War #1 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Family 6. (c) Age of husband or wife if alive \_\_\_\_\_ years (Day) (Year)

7. Birth date of deceased December 9 1887  
(Month) (Day) (Year)

8. AGE: Years 58 Months 4 Days 27 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Spencerburg Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Dentist

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

12. Name Sylvester Pagon

13. Birthplace Linnical Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Carrie Norman

15. Birthplace Linnical Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Dr. James H. Pagon

(b) Address Linnical, Mo.

17. (a) Burial (b) Date thereof May 7, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Berkley Cemetery

18. (a) Signature of funeral director James O. Gagnett

(b) Address Linnical Mo.

19. (a) 5-7-46 (b) Dr. E. M. Lucke  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month May day 5  
year 1946 hour \_\_\_\_\_ minute 11:45 A.M.

21. I hereby certify that I attended the deceased from January 15, 1945 to April 20, 1946  
and that death occurred on the date and hour stated above May 1, 1946

Immediate cause of death Myocarditis Duration 1 year  
Due to Cardio-Vascular Sclerosis 5 years

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

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

**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)  
(c) Means of injury \_\_\_\_\_

23. Signature Ferdinand B. Sawyer, MD (M. D. certificate)  
Address 1910 Market St. Date signed 5/6/46

WRITE PLAINLY—USE UNFADING INK—MAKE A PERMANENT RECORD

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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..... *A. M. O'Donnell*.....

Licensed Embalmer No..... *3889*.....

P. O. Address..... *Hannibal, Mo.*.....

**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.**