S. No. 2
M—8-43
5-17-39
P I X37[illegible]

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 20 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 28030

Registration District No. 281 Primary Registration District No. 5968 Registrar's No. 47

1. PLACE OF DEATH:

(a) County Polk

(b) City or town South Benton Township (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) 1 ½ years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Polk 84

(c) City or town Rural (If outside city or town limits, write "RURAL") 0

(d) Street No. (If rural, give location) 0

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Julia Elvina Agee

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Nov (Month) 1 (Day) 1868 (Year)

8. AGE: Years 77 Months 9 Days If less than one day hr. min.

9. Birthplace Vernon Co (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation House Work

11. Industry or business House Work

FATHER
12. Name William O. Agee
13. Birthplace Missouri (City, town, or county) 0 (State or foreign country)

MOTHER
14. Maiden name Verast
15. Birthplace France (City, town, or county) 5 (State or foreign country)

16. (a) Informant W.A. Agee
(b) Address Halfway Mo

17. (a) Scoffield (Burial, cremation, or removal) (b) Date thereof Aug (Month) 3 (Day) 46 (Year)
(c) Place: burial or cremation Scoffield

18. (a) Signature of funeral director L. B. Jones
(b) Address Buffalo Mo

19. (a) Aug 5, 1946 (Date received local registrar) (b) Ralph Garden (Registrar's signature) by [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 1 year 1946 hour 1 minute 30 M.

21. I hereby certify that I attended the deceased from about Jan 1 1946 to Aug 1 1946 that I last saw her alive on July 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic Valvular heart disease, Aortic & Mitral	years
Due to: Chronic Rheumatic disease	years
Due to:	
Other conditions: Age & Obesity (Include pregnancy within 3 months of death)	

Major findings: Of operations None - 92

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) 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 0

23. Signature [illegible] (M. D. or other) MD

Address Buffalo Mo Date signed 8-2-46

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 7-46-836
Date Filed 8-15-46

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. 4329

P.O. Address Buffalo, 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.