

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 18256  
Registrar's No. 1239

Registration District No. 377

Primary Registration District No. 6076

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

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Jennings  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
7010 Lena  
(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 Winniefred Bagley

3. (b) If veteran, name war None 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Otis 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased June 19 1899  
(Month) (Day) (Year)

8. AGE: Years 48 Months 10 Days 26 If less than one day hr. min.

9. Birthplace Luling Texas  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Self

12. Name Unknown Branyon

13. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Otis Bagley

(b) Address 7010 Lena

17. (a) Burial (b) Date thereof 5/17/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fayette, Alabama

18. (a) Signature of funeral director Provost Und. Co.

(b) Address 3710 N. Grand Blvd

19. (a) 5-17-48 (b) Beulah Hampton  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96  
(c) City or town Jennings 0  
(If outside city or town limits, write "RURAL") 0  
(d) Street No. 7010 Lena 0  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15  
year 1948 hour 5 minute 00 A. M.

21. I hereby certify that I attended the deceased from Oct 4  
1947 19. to May 15 1948;  
that I last saw her alive on May 12 1948;  
and that death occurred on the date and hour stated above.

Immediate cause of death Auto Caray Occlusion 1.0  
Duration \_\_\_\_\_

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

Due to Hypertension 4.40

Other conditions 946  
(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) Means of injury \_\_\_\_\_

23. Signature J. J. Ryan (M. D. or other) MD  
Address 12402 S. Dixie Date signed 5/17/48

