

FILED JUL 19 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 25596
Registrar's No. 2651

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>3064</u>		Registrar's No. <u>2651</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY <u>St. Louis</u>		b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Ferguson</u>		a. STATE <u>Missouri</u>		b. COUNTY <u>St. Louis</u>	
c. LENGTH OF STAY (in this place) <u>6 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Ferguson</u>		d. STREET ADDRESS (If rural, give location) <u>10 Tiffin Ave.</u>		e. TOWN <u>10 Tiffin Ave.</u>	
3. NAME OF DECEASED				4. DATE OF DEATH		5. SEX	
a. (First) <u>Agnes</u>		b. (Middle)		c. (Last) <u>Darragh</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Aug. 7, 1883</u>		9. AGE (In years last birthday) Months Days Hours Min. <u>67</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Sedalia, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13a. FATHER'S NAME <u>Maurice S. Barrett</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Lamm</u>	
14. NAME OF HUSBAND OR WIFE <u>Nelson R. Darragh</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Nelson R. Darragh 10 Tiffin Ave.</u>	
18. CAUSE OF DEATH				MEDICAL CERTIFICATION			
Enter only one cause per line for (a), (b), and (c)				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cachexia progressive</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Carcinoma of ascending colon & metastases</u>		<u>1 mos.</u>	
				DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>153X</u>				19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of ascending colon & metastases</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>51</u> , to <u>12 July</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>12 July</u> , 19 <u>51</u> , and that death occurred at <u>5:10</u> p. m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Joseph S. Gandy M.D.</u>				23b. ADDRESS <u>212 S. Flouissant Ferguson Mo</u>		23c. DATE SIGNED <u>7/12/51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7/14/51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>7-14-51</u>				REGISTRAR'S SIGNATURE <u>Herbert R. Donike</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>White Chapel, Ferguson, Mo.</u>	

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

R. M. White

Licensed Embalmer No. *3973*

P. O. Address

Terre Haute, Ind.

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.