

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029902

FILED VS AUG 24 1959

STATE FILE NUMBER

Registration District No. 231 Primary Registration District No. _____ Registrar's No. 197

DED

1. PLACE OF DEATH a. COUNTY <u>Madawasky</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Stensley</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>East of Maryville</u>		Length of stay in 1b <u>1 day</u>		c. CITY OR TOWN <u>Stensley</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>IN AMBULANCE ON way to Hospital Pabbtown</u>				Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>N. Walnut</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EUGENE LOREN AGE</u>				4. DATE OF DEATH Month Day Year <u>August 16 1959</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-17-97</u>	9. AGE (last birthday) <u>62</u>	IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee Howe Store</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hardware Store</u>		11. BIRTHPLACE (City and state or country) <u>Whitehall MO</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Wm Agee</u>		13b. MOTHER'S MAIDEN NAME <u>Mrs O Lamb</u>		14. NAME OF HUSBAND OR WIFE <u>Proverdie Agee</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>491-28-6022</u>		17. INFORMANT <u>Proverdie Agee</u> Address <u>Stensley MO</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Compression, internal hemorrhage 12 hrs & fractured cervical spine</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Compound fracture</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Head on automobile collision</u>					
20c. TIME OF INJURY Hour Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Arden Co, Hi 169</u>		20f. CITY, TOWN, OR LOCATION <u>Lang City</u>		COUNTY <u>DeKalb</u>		STATE <u>Missouri</u>	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>about 9 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>B. F. Byland M.D.</u>				22b. ADDRESS <u>Marionville MO</u>		22c. DATE SIGNED <u>8/18/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) _____		23b. DATE <u>8-18-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>High Ridge</u>		23d. LOCATION (City, town, or county) (State) <u>Stensley Stensley MO</u>	
24. FUNERAL DIRECTOR <u>Phillip Montwary</u> ADDRESS <u>Stensley MO</u>				25. DATE RECD. BY LOCAL REG. <u>8 18 59</u>		26. REGISTRAR'S SIGNATURE <u>Bess Toltz</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

(Dr. Byland)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, ~~Student Embalmer No.~~
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John F. Phillips

Licensed Embalmer No. 1898

P. O. Address Stoughton

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.