

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

19687

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **003**

City **St. Louis Mo.** (No. **3921 N. 21st St.**)

File No.

Registered No. **52943**

St. Ward)

2. FULL NAME

(a) Residence. No. **3921 N. 21st St.** St. **20** Ward.

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Margaret E. Hagler**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **April 29 - 1885**

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
74 - 13

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Custodian of**
(b) General nature of industry, business, or establishment in which employed (or employer) **Pres. Church**
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Ills.**
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER **John W. Hagler**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

12. MAIDEN NAME OF MOTHER **M. Crawford**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

14. INFORMANT **Margaret E. Hagler**
(Address) **3921 N. 21st St.**

15. FILED **MAY 13 1929** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **May 12th 1929**

17. I HEREBY CERTIFY, That I attended deceased from **5/11**, 19**29**, to **5/12**, 19**29** that I last saw him alive on **5/12**, 19**29**, and that death occurred, on the date stated above, at **7 A.** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Dilatation of Heart (duration) **2** yrs. **2** mos. **2** ds.
CONTRIBUTORY **Brain & Face Reader** (SECONDARY)
Dr. Hall Stones (duration) **10** yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? **No** DATE OF.....

WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS **Physical**

(Signed) **H. Meador** M. D.

5/7, 19**29** (Address) **23rd St. St. Louis**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Troy, Ills.** DATE OF BURIAL **May 14 1929**

20. UNDERTAKER **Ray Leidner** ADDRESS **1417 N. Market**

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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