

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

Do not use this space.

37781

File No. _____
Registered No. 787
St. 5 Ward

1. PLACE OF DEATH

County Mason Registration District No. 547
Township Mason Primary Registration District No. 302A
City Hannibal (No. 821, Vermont)

2. FULL NAME

William Fredrick Hagen
(a) Residence. No. 821 Vermont St. 5 Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 20 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) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary Hagen

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 22-1880

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
79 8 27

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Salesman
(b) General nature of industry, business, or establishment in which employed (or employer). Nursery Co Knight & Bestwick
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lancaster, Penn.

10. NAME OF FATHER August Hagen

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

12. MAIDEN NAME OF MOTHER Mont Know

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

14. INFORMANT (Address) Mrs. Walter Jeffery's Hannibal Mo.

15. FILED 11/20/29 C. Clausius REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 19-1929

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1929, to Nov. 19, 1929, that I last saw him alive on Nov. 18, 1929, and that death occurred, on the date stated above, at 12:10 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) SI (duration) 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 clinical
(Signed) E. R. Motley, M. D.
11/19-1929 (Address) Hannibal-Mo.

*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 Mt. Olivet Cemetery DATE OF BURIAL 11-21-1929

20. UNDERTAKER Schwartz Funeral Home Hannibal Mo. ADDRESS

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

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