

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

Do not use this space.

28518

**1. PLACE OF DEATH**

County St. Louis Registration District No. 791  
Township St. Louis Primary Registration District No. 103  
City St. Louis (No. Mo. Baptist Hospital)

File No. \_\_\_\_\_  
Registered No. 8423  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Fannie Marie Hagen  
(a) Residence. No. 5420 Mendenhall ave St. 14 Ward. \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)  
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.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married  
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 16, 1892  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
38 6 6

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

9. BIRTHPLACE (CITY OR TOWN) Kansas  
(STATE OR COUNTRY)

**PARENTS**  
10. NAME OF FATHER Benton C. Blisig  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Pennsylvania  
(STATE OR COUNTRY)  
12. MAIDEN NAME OF MOTHER Carrie Corley  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Illinois  
(STATE OR COUNTRY)

14. INFORMANT Emil M. Hagen  
(Address) 5420 Mendenhall ave

15. FILED AUG 25 1930 May C. Starkey REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

3  
16. DATE OF DEATH (MONTH, DAY AND YEAR) August 22 1930  
17. I HEREBY CERTIFY, That I attended deceased from Aug 15, 1927, to Aug 22, 1930 that I last saw her alive on Aug 22, 1930, and that death occurred, on the date stated above, at 1:30 A. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Arteriosclerosis  
1245  
10085 D B  
1078 (duration) 3 yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
CONTRIBUTORY hemorrhage from  
(SECONDARY) esophageal varix sudden  
(duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED home  
IF NOT AT PLACE OF DEATH. \_\_\_\_\_  
DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? yes  
WHAT TEST CONFIRMED DIAGNOSIS yes  
(Signed) C. E. Gilliland, M. D.  
, 19 \_\_\_\_ (Address) 1116 Mo. Bldg.

\*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 Walkalla Cemetery DATE OF BURIAL 8-25 1930  
20. UNDERTAKER Kriegshauser Wood King Highway ADDRESS 19248

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.

