V. S. No. 2
M—11-10-39
ev. 5-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 5940

Registration District No. 85 — Primary Registration District No. 1001 — Registrar's No. 140

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2901 Olive St. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None (Specify whether

In this community None years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph (If outside city or town limits write "RURAL")

(d) Street No. 2901 Olive (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME James Franklin Hagan

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Mary Elizabeth Hagan

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased August 24th 1855 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
84	5	12	..... hr. ..... min.

9. Birthplace Jackson County (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business Own Farm

FATHER
12. Name William Hagan
13. Birthplace Unknown (City, town, or county) Virginia (State or foreign country)

MOTHER
14. Maiden name Mary Sedelia Wells
15. Birthplace Unknown (City, town, or county) Virginia (State or foreign country)

16. (a) Informant Carl Hagan

(b) Address 2909 Penn St. St. Joseph, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 8, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Auburn Cemetery

18. (a) Signature of funeral director Herman Wm Schuefader

(b) Address 1802 Union Str. St. Joseph, Mo.

19. (a) Feb 7, 1940 (Date received local registrar) (b) H. J. Neotlebeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Febr. day 6th year 1940 hour 2 minute 00 A.M.

21. I hereby certify that I attended the deceased from Jan 31, 1940, to Feb 6, 1940 that I last saw him alive on Feb 5, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Terminal Sub-Acute Bronchitis Arteriosclerosis

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) none

Major findings: Of operations no operation

Of autopsy no autopsy

Duration: 14 days; several years

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

85 While at work? (e) Means of injury

23. Signature Gordon D. Wright M.D. (M. D. or other)

Address 845 So 19th Saint Joseph Mo. Date signed 2/7/40

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Albert E. Harrington

Licensed Embalmer No. 3258

P. O. Address St. Joseph, Mo.

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, above space should be left blank.