

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.

Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County St. Louis.
(b) City or town St. Louis.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Alexian Bros. Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community Life.
years, months or days

3. (a) PRINT FULL NAME Joseph Hagenbrock **251**
3. (b) If veteran, name war _____ 3. (c) Social Security No. 492-05-1250

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mae Hagenbrock 6. (c) Age of husband or wife if alive 32 years
7. Birth date of deceased April 21 1905
(Month) (Day) (Year)

8. AGE: Years 35 Months 1 Days 2 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Foreman
11. Industry or business Paint Co.

MOTHER FATHER
12. Name Joseph Hagenbrock
13. Birthplace St. Louis Mo. (City, town, or county) (State or foreign country)
14. Maiden name Mary Grese
15. Birthplace St. Louis Mo. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mae Hagenbrock
(b) Address 2728 A Accomac St

17. (a) Burial (b) Date thereof May 25/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New S?S?Peter & Paul
18. (a) Signature of funeral director Shorcutis
(b) Address 2906 Gravois Ave.

19. (a) MAY 24 1940 (b) J. B. Budick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis. **2B**
(If outside city or town limits, write "RURAL")
(d) Street No. 2728 A Acomac St
(If rural, give location)
(e) If foreign born, how long in U. S. A. Life. years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 23
year 1940 hour 9 30 A.M. minute _____ M.
21. I hereby certify that I attended the deceased from May 13, 1940, to May 23, 1940;
that I last saw him alive on May 23, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death 5 Lobar pneumonia
Acute Glomerular Nephritis
Due to _____
Duration 3 days
7 days

Due to Acute tonsillitis & Pharyngitis
onset of which was 5 days
Other conditions Acute Cardiac Dilatation
(Include pregnancy within 3 months of death) non dephtheritic

Major findings: none
Of operations _____
Of autopsy 5 Lobar pneumonia
Acute Glomerular Nephritis

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) no
(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) _____
While at work? _____ (e) Means of injury _____
28. Signature J. B. Budick (M. D. or other) _____
Address 2728 A Accomac St Date signed 5/23/40

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.....

Leo Budde

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

working under my personal supervision.

Signed.....

Leo Budde

Licensed Embalmer No. *3989*

P. O. Address *St. Louis, 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.