

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

APR 15 1941

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 861

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution K.C. General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days (Specify whether years, months or days)
In this community 23 Years

3. (a) PRINT FULL NAME ANDREW REYNOLDS HAGER?

3. (b) If veteran, name war No 3. (c) Social Security No. No

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

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive ----- years

7. Birth date of deceased No Record
(Month) (Day) (Year)

8. AGE: Years 61 Months _____ Days _____ If less than one day hr. _____ min. _____

9. Birthplace Sweden 4 (City, town, or county) (State or foreign country)

10. Usual occupation Night Watchman

11. Industry or business Grocery Store

12. Name No Record

13. Birthplace Sweden 4 (City, town, or county) (State or foreign country)

14. Maiden name No Record

15. Birthplace Sweden 4 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Stabila

(b) Address 1413 Bales

17. (a) Burial (b) Date thereof March 3, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)
Green Lawn

(c) Place: burial or cremation

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address 918 Brooklyn, K. C. Mo.

19. (a) 2/1/41 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 1229 Monroe 8
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country Do not know

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 27th
year 1941 hour 7 minute 25 A. M.

21. I hereby certify that I attended the deceased from 2-24-41 to 2-27-41
that I last saw him alive on 2-27-41
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia; hypertrophy of Heart

Due to 95C
Due to 95C

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy See above

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? _____

314
While at work? (Specify type of place) _____
Means of injury 0
23. Signature Dr. R. Shaw (M. D. or other)
Address Med. Dir. K.C. Gen. Hospital Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

48
3
4

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 *Daniel C. Browning*

Licensed Embalmer No. *2726*

P. O. Address *79. E. 2nd*

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, fact should be so stated above.