

FILED JUL 28 1942 91

1003

Registration District No.

Primary Registration District No.

Registrar's No.

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: Masonic Home of Missouri 5
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 10 yrs. 9 Mos.
 (Specify whether
 In this community _____
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 5381 Delmar
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country 0

3. (a) PRINT FULL NAME Bettie Hagan

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife J. H. Hagan 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 4, 1852
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
90 3 15 hr. min.

9. Birthplace Luray, Virginia
 (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Jos. Hisey

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

14. Maiden name Sarah Carter

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

16. (a) Informant Iva Hirsch

(b) Address 5351 Delmar, St. Louis, Mo.

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

(c) Place: burial or cremation Charleston, Missouri

18. (a) Signature of funeral director Albert H. Hoppe Inc.

(b) Address 4700 Washington Ave.

19. (a) (Date received local registrar) (b) J. P. Bruch (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19
 year 1942 hour 2 minute 35 P. M.

21. I hereby certify that I attended the deceased from Feb. 15
 19 36 July-19 19 42
 that I last saw her alive on July-19- 19 42
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Duration 1yr

Due to Chronic Interstitial Nephritis 6 Mo

Other conditions (Include pregnancy within 3 months of death) 181

Major findings: Of operations _____ Of autopsy 121

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?

23. Signature Alvin Cameron (M. D. or other) _____
 Address 508 N. 15th St. St. Louis Date signed _____

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

HEC

BEI

AK-

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..... *G. W. Wilkin*.....
Licensed Embalmer No..... *357*.....
P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **22798**

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **6139**

1. PLACE OF DEATH:

(a) County.....

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

(c) Name of hospital or institution: **Masonic Home of Mo.**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... **10 yrs 9 mos**
(Specify whether)

In this community.....
years, months or days)

3. (a) PRINT FULL NAME **Bethie Hagan**

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced..... **W**

6. (b) Name of husband or wife.....

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

7. Birth date of deceased **April 4 1855**
(Month) (Day) (Year)

8. AGE: Years **90** Months **3** Days **12** If less than one day..... min.

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

10. Usual occupation **Industrial Home - 12 years**

11. Industry of business **none**

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a) **Removal** (b) Date thereof **7-21-42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) **SEP 5 1942 J. F. Bredsch**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

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

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

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** Day **19** Year **1942** hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....
that I last saw him..... alive on..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations.....

Of autopsy.....

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?
While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature..... (M. D. or other).....
Address..... Date signed.....

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

SUPPLEMENTARY

S-22798