

REG. AUG 26 1943 317  
Registration District No. **317**

Primary Registration District No. **3063**

Registrar's No. **1912**

1. PLACE OF DEATH:

(a) County **St. Louis**  
(b) City or town **Clayton**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**St. Louis County Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **1 day**  
(Specify whether years, months or days)  
In this community **35 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **St. Louis**  
(c) City or town **Clayton OVERLAND**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **8717 Carshire**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country **-----**

3. (a) PRINT FULL NAME

**Hagner, Joseph**

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

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

6. (b) Name of husband or wife **Bridget O'Rourke** 6. (c) Age of husband or wife if alive **62** years

7. Birth date of deceased **JUNE 20 1881**  
(Month) (Day) (Year)

8. AGE: Years **62** Months **2** Days **0** If less than one day **hr. min.**

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

10. Usual occupation **Watchman**

11. Industry or business **-----**

12. Name **Hager, Joseph**

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

14. Maiden name **Margaret Conling**

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

16. (a) Informant **Wife, Brigdet**

(b) Address **8717 Carshire, Overland,**

17. (a) **BURIAL** (b) Date thereof **8-23-43**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **CALVARY Cem.**

18. (a) Signature of funeral director **DRITMANN FUNERAL Home**

(b) Address **9222 Backland, Overland, Mo**

19. (a) **AUG 24 1943** (b) **C. J. McShannon, M.D.**  
(Date of registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **20**  
year **1943** hour **7:45** minute **P.** M.

21. I hereby certify that I attended the deceased from **8-19-43**  
19..... to..... **8-20-43** 19.....;

that I last saw h. **im** alive on..... **8-20-43** 19.....;

and that death occurred on the date and hour stated above.  
Immediate cause of death **Subarachnoid Hemorrhage**

Due to **Fractured Skull** **1 day**

Due to **-----**

Other conditions **Hypertension Acute Urinary Retention**  
(Include pregnancy within 3 months of death)

Major findings: Of operations **-----**

Of autopsy **-----**

Duration

**1 day**

**1 day**

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) **accident, D.P.**

(b) Date of occurrence **8-19-43**

(c) Where did injury occur? **Overland, Mo.**  
(City, town, or county) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
**Neighborhood Grocery store**

While at work? **no** (Specify type of place) (e) Means of injury **skull fracture**

23. Signature **John H. Hadermier** (M.D. or other) **M.D.**

Address **St. Louis County, Mo** Date signed **8-21-43**

AUG 26 194

**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 Al C Ostmann

Licensed Embalmer No. 3478

P. O. Address.....

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Sept.

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town Overland  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis Co. Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day (Specify whether  
In this community 35 yr. years, months or days)

3. (a) PRINT FULL NAME Joseph Hagner  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m  
6. (b) Name of husband or wife Bridget O'Rourke 6. (c) Age of husband or wife if alive 62 years  
7. Birth date of deceased June 26 - 1881 (Month) (Day) (Year)

8. AGE: Years 62 Months 2 Days 00 (If less than one day, min.)

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

10. Usual occupation Auto man

11. Industry or business \_\_\_\_\_

12. Name Joseph Hagner

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

14. Maiden name Coning, Margaret

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

16. (a) Informant Wife

(b) Address 8717 Caroline, Overland, Mo.

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

(c) Place: burial or cremation \_\_\_\_\_

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

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County St. Louis  
Overland  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. 8717 Caroline (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Year 1943 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from 8-19-43 to 8-20-43, 19\_\_\_\_; that I last saw him/her live on 8-20-43, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death intracranial hemorrhage fractured skull.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions Hypertension (Include pregnancy within 3 months of death)  
acute urinary retention

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
1860  
39

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence 8-19-43

(c) Where did injury occur? St. Louis County, Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
public place  
While at work? no (Specify type of place) (e) Means of injury FALL

23. Signature John Niederwieser (M. D. or other) MD.  
Address St. Louis County Hosp Date signed 8-31-43

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

Supplemental

Physician

29300