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FILED SEP 2 1943

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29651

Registration District No. 374 Primary Registration District No. 6273 Registrar's No.

1. PLACE OF DEATH:
(a) County Worth
(b) City or town Grant City Mo (rural) (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: [illegible]
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 9 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Worth
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. Grant City, Mo. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME (No name)

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 0

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

7. Birth date of deceased July (Month) 18 (Day) 1943 (Year)

8. AGE: Years Months Days 9 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name Raymond Hagan
13. Birthplace Gladys (City, town, or county) Kansas (State or foreign country)

MOTHER
14. Maiden name Kathryn G. Wall
15. Birthplace Breckenridge (City, town, or county) Minn (State or foreign country)

16. (a) Informant Raymond Hagan
(b) Address Grant City Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-29-43 (Month) (Day) (Year)
(c) Place: burial or cremation Honey Grove Cemetery

18. (a) Signature of funeral director [illegible] C Dunfey
(b) Address Grant City, Mo.

19. (a) Aug 16-1943 (Date received local registrar) (b) Arthur Scadden (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 27 year 1943 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from Birth July 18 -1943, 19..., to ..., 19...;
that I last saw him alive on July 27 1943, 19...
and that death occurred on the date and hour stated above.

Immediate cause of death Sibal Bufidia
Hydro Sephalis

Duration 9 Days

Due to Error of development at Birth

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

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)
While at work? (e) Means of injury

23. Signature O L Fullerton M.D. or other
Address Bedford Ia. Date signed 8/2/43

1164 (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 Jack C. Dunlee

Licensed Embalmer No. 3252

P. O. Address Grant City

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 29651

Registration District No. 374 Primary Registration District No. 6273 Registrar's No.

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

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

3. (a) PRINT FULL NAME No Name

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 S

6. (b) Name of husband or wife

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

7. Birth date of deceased July (Month) 18 (Day) 88 (Year)

8. AGE: Years Months Days If less than one day hrs. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

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

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

19. (a) (Date received local registrar) (b) Arlene Scadden (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 21 year 1943 hour minute M.

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

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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)
While at work? (e) Means of injury

23. Signature D. L. Swallentine (M. D. or other) M.D.
Address Redding Ia. Date signed 7/28/43

SUPPLEMENTARY

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...TE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD