

FILLED JAN 12 1944 318

Registration District No. _____ Primary Registration District No. 1002

Registrar's No. 11894

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Saint Louis Maternity Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 3 Hours
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Infant ~~Female~~ Hagan

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

4. Sex Female 5. Color or race White 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 November 22, 1943
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 3 hr. 10 min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name John Roy Hagan
13. Birthplace Minnesota _____
(City, town, or county) (State or foreign country)
14. Maiden name Ethel Marie Simonson
15. Birthplace Minnesota _____
(City, town, or county) (State or foreign country)

16. (a) Informant Saint Louis Maternity Hosp.
(b) Address 630 S. Kingshighway

17. (a) Autopsy (b) Date thereof DEC 31 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington University DEC 31 1943

18. (a) Signature of funeral director W. Reeder - 3500 Rutger
(b) Address _____

19. (a) W. Reeder (b) J. Z. Bruders
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 11
(c) City or town St. Louis 93
(If outside city or town limits, write "RURAL")
(d) Street No. 2715a Ann Avenue
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 22
year 1943 hour 3 minute 10 P.M.

21. I hereby certify that I attended the deceased from Nov. 22, 1943 to Nov. 23, 1943;
that I last saw him alive on Nov. 23, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Atelectasis of both lungs.

Due to Prothrombin of cord.

Due to _____

Other conditions 1/6/1
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy As noted

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 W. Reeder (M. D. or other) W.D.
Address 630 S. Kingshighway Date signed 12/23/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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.....

Licensed Embalmer No.....

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.