

No. 2  
-5-42  
5-17-39  
X32873

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED MAY 11 1945

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14051

State File No. ....

Registrar's No. 1

Registration District No. 230

Primary Registration District No. 5810

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

1. PLACE OF DEATH:

(a) County Montgomery Co.  
(b) City or town New Florence, Mo. Rural  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 49 years  
In this community 49 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County Montgomery.  
(c) City or town New Florence, Mo. Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. ....  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Mrs Henrietta Hagedorn.

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

4. Sex Female / 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Henry Hagedorn. 6. (c) Age of husband or wife if alive years  
7. Birth date of deceased April 15th, 1860  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
84 II 20 hr. min.

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

10. Usual occupation Housewife

11. Industry or business.....

12. Name William Holtwick.  
13. Birthplace Unknown German.  
(City, town, or county) (State or foreign country)  
14. Maiden name Alda Hewing.  
15. Birthplace Unknown German.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Dillard Landrum,  
(b) Address New Florence, Mo. RFD

17. (a) Burial (b) Date thereof April 8th,  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clark Cemetery.

18. (a) Signature of funeral director Walter  
(b) Address Americus, Mo.

19. (a) 4-8-1945 (b) Mrs Frank Overkamp  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 5th,  
year 1945 hour 2 minute A.M.

21. I hereby certify that I attended the deceased from 2-15  
1945 to 4-5 1945  
that I last saw h. er. alive on 4-4 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial pneumonia Duration 3 days  
Due to Cerebral Haemorrhage 1 day.

Due to Chronic arterio-sclerotic nephritis ?

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.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....  
(b) Date of occurrence 4

(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 Jamer O. Helm (M. D. or other)  
Address New Florence Mo. Date signed 4-6-45

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 5-10-45

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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.....

D. B. Baker, Registered Apprentice No.....

working under my personal supervision.

Signed *D B Baker*

Licensed Embalmer No. 3375

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.**

Registration District No. 230

Primary Registration District No. 5810

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

1. PLACE OF DEATH:

(a) County Montgomery

(b) City or town Rural South Zug  
(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 Henrietta Hagedorn

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 wid

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

6. (c) Age of husband or wife if alive \_\_\_\_\_ year

7. Birth date of deceased April 15 1888  
(Month) (Day) (Year)

8. AGE: Years 84 Months 11 Days 28  
(If less than one day) min.

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

10. Usual occupation \_\_\_\_\_

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

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

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

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April  
year 1945 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 chronic nephritis

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy 13/16

Duration \_\_\_\_\_

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

23. Signature James O. Helm (M. D. or other) 5-12-45  
Address New Florence Date signed \_\_\_\_\_

14051