V. S. No. 2
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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 8 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 42807

Registration District No. 374 Primary Registration District No. 45-49 Registrar's No.

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

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

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

3. (a) PRINT FULL NAME Mary Ella Hagens
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F 1
5. Color or race W
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband ~~or wife~~ W. H. Hagens
6. (c) Age of husband or wife if alive years
7. Birth date of deceased (Month) (Day) (Year)
8. AGE: Years 96 Months 8 Days 5 If less than one day hr. min.
9. Birthplace Paris Dell / (City, town, or county) (State or foreign country)
10. Usual occupation House wife
11. Industry or business
MOTHER FATHER
12. Name Jessie Bisk
13. Birthplace Gallmeadow / (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Beby Morris
15. Birthplace Ohio / (City, town, or county) (State or foreign country)
16. (a) Informant C. C. Merckling
(b) Address Grant City Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-17-45 (Month) (Day) (Year)
(c) Place: burial or cremation Isadora Mo
18. (a) Signature of funeral director Geo Andrews
(b) Address Grant City Mo
19. (a) Dec 29-1945 (Date received local registrar) (b) Leta E. Dawson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 14
year 1945 hour 11:00 minute P.M.
21. I hereby certify that I attended the deceased from 12-8 1945 to 12-14 1945
that I last saw her alive on 12-14 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage (Hypertension)	3 days
Due to:	
Due to: ✓	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: ✓	
Of autopsy: None	

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 B. Rees M.D. (M., D., or other)
Address Grant City Mo Date signed 12-15-45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 11,
District File Number
Date Filed

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 Hays Quedens

Licensed Embalmer No. 2892

P. O. Address Ukiah 1190

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.