

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 374

Primary Registration District No. 4547

Registrar's No. 10

1. PLACE OF DEATH:

(a) County North
(b) City or town Grant city
(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 Life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County North
(c) City or town Grant city
(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 HATTIE ELIZABETH HAGANS

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Scott Hagans 6. (c) Age of husband or wife if alive 85 years
7. Birth date of deceased Aug 2 1864
(Month) (Day) (Year)

8. AGE: Years 81 Months 5 Days 16 If less than one day hr. min.

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

10. Usual occupation Housewife

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 18
year 1946 hour 6 minute 15 P.M.
21. I hereby certify that I attended the deceased from Jan 14 46
_____, 19____, to 1-18, 1946
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Obstruction of bowels Duration 5 days

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 5 months of death)
Major findings: **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**
Of operations
Of autopsy no **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 E. J. Ross M.D. (M. D. or other)
Address Grant City Mo Date signed 1-19-46

MOTHER FATHER

11. Industry or business _____
12. Name Bernard E. Drummond
13. Birthplace unknown Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Hurst
15. Birthplace unknown Ohio
(City, town, or county) (State or foreign country)
16. (a) Informant Scott Hagans
(b) Address Grant city, Mo.
17. (a) Burial (b) Date thereof 1-20-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Honey Lodge Cem
18. (a) Signature of funeral director John C. Duffler
(b) Address Grant city, Mo.
19. (a) Jan 28 1946 (b) Hattie E. Dawson
(Date received local registrar) (Registrar's signature)

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

3463

3

**DISTRICT HEALTH OFFICE
Cameron, Mo.**

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.....

Arch C. Dingle

Licensed Embalmer No.

3252

P. O. Address.....

Levant City, Mo.

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.

Feb

Registration District No.

374

Primary Registration District No.

4587

Registrar's No.

10

1. PLACE OF DEATH:

(a) County *Worth*
(b) City or town *Grant City*
(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)

3. (a) PRINT FULL NAME *Hettie E. Hagan*

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 *m*

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

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years *81* Months *6* Days *6* If less than one day hr. min.

9. Birthplace (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) (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) (Registrar's signature)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Feb* Year *1946* hour minute M.

21. I hereby certify that I attended the deceased from to

that I had seen him alive on and that death occurred on the date and hour stated above.

Duration of immediate cause of death *Structural Spinal Cord Lesion of Squamous Cells*

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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 (M. D. or other)

Address *Grant City Mo* Date signed *2/15/46*

SUPPLEMENTARY

**ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED**

PHYSICIAN
460
Underline the cause to which death should be charged statistically.

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

3465

4415