S. No. 2
I—8-43
5-17-39
P I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 16 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 18096

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 970

1. PLACE OF DEATH:

(a) County St Louis County (St Ferdinand)
(b) City or town (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Hails Ferry Memorial Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 weeks (Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 000
(c) City or town St Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 5043 Maple 9
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Missouri Tator Race
3. (b) If veteran, name war nil
3. (c) Social Security No. nil
4. Sex female
5. Color or race W
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb (Month) 6 (Day) 1860 (Year)

8. AGE: Years 86 Months 2 Days 25 If less than one day hr. min.

9. Birthplace St Louis (City, town, or county) Mo (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name Abram S Hoagland
13. Birthplace ~~Naomi~~ (City, town, or county) NJ (State or foreign country)
MOTHER
14. Maiden name Naomi
15. Birthplace (City, town, or county) NJ (State or foreign country)
16. (a) Informant Walter Tator
(b) Address 5043 Maple
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-3-46 (Month) (Day) (Year)
(c) Place: burial or cremation Bellefontaine
18. (a) Signature of funeral director Guy Mullen
(b) Address 5041 Delmar
19. (a) 5-4-46 (Date received local registrar) (b) E. D. McGovran MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 1st year 1946 hour 5 minute P. M.
21. I hereby certify that I attended the deceased from March 26, 1946 to May 1, 1946 that I last saw her alive on May 1, 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma of bowels	
Due to — 46	
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) No
(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 H. S. Chavez (M. D. ~~or other~~)
Address Findell Trust Bldg Date signed 5-3-46

(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.....

Licensed Embalmer No. 3681

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.