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

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 38661

FILED DEC 2 1946

Registration District No. 918 Primary Registration District No. 1003 Registrar's No. 9970

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution St. Louis City Hospital
Max C. Starkloff Memorial
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 4320a DeTonty
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME HAGEN, PETER

3. (b) If veteran, name war no

3. (c) Social Security No.

4. Sex male

5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Ethel

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased November (Month) 18 (Day) 1881 (Year)

8. AGE: Years 65 Months 0 Days 1 If less than one day hr. min.

9. Birthplace Norway (City, town, or county) 4 (State or foreign country)

10. Usual occupation Elevator operator

11. Industry or business

FATHER
12. Name John Hagen
13. Birthplace Norway (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Norway (City, town, or county) 4 (State or foreign country)

16. (a) Informant Mrs. Ethel E. Hagen

(b) Address 4320a DeTonty

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 11-22-46 (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews Cemetery

18. (a) Signature of funeral director Chas. A. Bull

(b) Address 4452 Washington Blvd.

19. (a) NOV 22 1946 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 19 year 1946 hour 10:50 minute P M.

21. I hereby certify that I attended the deceased from May 6, 1946, to November 19, 1946 that I last saw him alive on November 19, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Prostate with retro peritoneal metastases, and bone metastases — Duration 4 yrs.

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Transurethral resection — Ca. of prostate 1942

Of autopsy Ca of Prostate & metastases to regional nodes

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature E. M. Fillman (M. D. or other)

Address 1515 Lafayette Avenue Date signed 11/20/46

(Licensed Embalmer's Statement on Reverse Side)

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 John Keller

Licensed Embalmer No. 3880

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.