

FILED AUG 6 1947

Registration District No. 43

Primary Registration District No. 3007

1. PLACE OF DEATH:

(a) County BUTLER  
(b) City or town Poplar Bluff  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Poplar Bluff Hosp.  
(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) 3 days

3. (a) PRINT FULL NAME AUBREY DEAN HAGER

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

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced \_\_\_\_\_

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

7. Birth date of deceased JUNE 14 '47  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
0 1 15 hr. \_\_\_\_\_ min.

9. Birthplace Success ARK 1  
(City, town, or county) (State or foreign country)

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

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

12. Name ANDY HAGER  
13. Birthplace WARM SPRING ARK 1  
(City, town, or county) (State or foreign country)  
14. Maiden name GETTIE WINTLANDER  
15. Birthplace RENO ARK 1  
(City, town, or county) (State or foreign country)

16. (a) Informant ANDY HAGER  
(b) Address Success ARK

17. (a) Burial (b) Date thereof 7 31 47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation JOHNSON Cem.

18. (a) Signature of funeral director W. D. [Signature]  
(b) Address RECTOR ARK

19. (a) 8/1/47 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State ARK (b) County CLAY 999  
(c) City or town Success 3  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location) 0  
(e) Citizen of foreign country? Yes (Yes or No) 2  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 30  
year 1947 hour 8:12 minute 4 M.

21. I hereby certify that I attended the deceased from July 27, 1947, to July 30, 1947,  
that I last saw him alive on July 30, 1947,  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia Duration 2 days

Due to Gastro-enteritis

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? \_\_\_\_\_  
(Specify type of place) \_\_\_\_\_

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

Signature Frank E. Dineen (M. D. or other) MD  
Address Poplar Bluff Mo. Date signed 7/30/47

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

2  
7  
3

RECEIVED

District Health Office No. 2,

District File Number

Date Filed

877-1057

8-1-42

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.....

*C. P. Selman*

Registered Apprentice No. *263*

working under my personal supervision.

Signed.....

*W. J. Jolley*

Licensed Embalmer No. *264*

P. O. Address.....

*Rector, Ark*

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.