. No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
U. S. Office of Vital Statistics

FILED AUG 15 1947
#73943

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 25592

Registration District No. 318 — Primary Registration District No. 1003 — Registrar's No. 2354

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 (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 000
(c) City or town ST. LOUIS 17 (If outside city or town limits, write "RURAL")
(d) Street No. 3417 INDIANA 9 Memorial (If rural, give location)
(e) Citizen of foreign country? 24 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME LILLIE HAPGOOD
3. (b) If veteran, name war —
3. (c) Social Security No.

4. Sex FEMALE
5. Color or race W
6. (a) ~~Single~~, widowed, married, ~~divorced~~ MARRIED
6. (b) Name of husband or wife WILLIAM H. HAPGOOD
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept. 28 1871 (Month) (Day) (Year)

8. AGE: Years 75 Months 10 Days 7 If less than one day hr. min.

9. Birthplace ST. LOUIS (City, town, or county) MO (State or foreign country)
10. Usual occupation NIL
11. Industry or business
FATHER 12. Name DR. THEO. FAY 4
13. Birthplace ENGLAND (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name NANCY
15. Birthplace UNK 9 (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. M. Hapgood
(b) Address 3417 Indiana Av.
17. (a) BURIAL (Burial, ~~cremation, or removal~~) (b) Date thereof AUG 7 47 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ NEW ST. MARCUS
18. (a) Signature of funeral director E. T. Schnur
(b) Address 3125 Lafayette Av.
19. (a) AUG 6 1947 (Date received local registrar) (b) J. F. Budeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 5th year 1947 hour 3:00 minute P. M.
21. I hereby certify that I attended the deceased from 7/31/47, 19..., to Aug. 5th, 19 47 that I last saw her alive on Aug. 5th, 19 47 and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Pernicious anemia
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

PHYSICIAN — Underline the cause of 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 John R. Coughead M.D. (M.D., coroner)
Address 1515 Lafayette Date signed 8/5/47

Jefferson City Printing Co. (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 Jos B Wollman

Licensed Embalmer No. 4614

P. O. Address 3125 Eugenia Ave

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.