No. 2
1/47
17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29090

FILED AUG 21 1947

Registration District No. 318 — Primary Registration District No. 1003 — Registrar's No. 7698

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: 6-wks. (Specify whether years, months or days)

In this community: 30 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County:

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

(d) Street No.: 4447a Manchester Ave. (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME: JANE HAGAN (O'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: OWen O'Hagan

6. (c) Age of husband or wife if alive: 63 years

7. Birth date of deceased: Nov.31st.,1877 (Month) (Day) (Year)

8. AGE: Years: 69 Months: 8 Days: 10 If less than one day: hr. min.

9. Birthplace: Ireland (City, town, or county) (State or foreign country)

10. Usual occupation: At Home

11. Industry or business:

MOTHER FATHER

12. Name: John Hughes

13. Birthplace: Ireland (City, town, or county) (State or foreign country)

14. Maiden name: Margaret Unknown

15. Birthplace: Ireland (City, town, or county) (State or foreign country)

16. (a) Informant: Mr.Owen O'Hagan

(b) Address: 4447a Manchester Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8-14-47 (Month) (Day) (Year)

(c) Place: burial or cremation: Calvary

18. (a) Signature of funeral director: Arthur J. Donnelly

(b) Address: 3840 Lindell Blvd.

19. (a) AUG 15 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Aug. day: 11th year: 1947 hour: 2:55 minute: P.M.

21. I hereby certify that I attended the deceased from: 6/15/47, 19..., to: Aug. 11th, 19 47 that I last saw her alive on: Aug. 11th, 19 47 and that death occurred on the date and hour stated above.

Duration

Immediate cause of death: Acute pulmonary embolism

Due to: Post-vaginal hysterectomy (prolapsed uterus)

Due to:

Other conditions: Psychosis & cerebral arteriosclerosis (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:

Signature: Everett Green M.D. or other

Address: 1515 Lafayette Date signed: 8/11/47

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 W M Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

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.