

1. PLACE OF DEATH:

(a) County Osage
(b) City or town Argyle
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days Yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Osage
(c) City or town Argyle
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JOSEPH BERNARD LAGER

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

4. Sex M.O. 5. Color or race W. 6. (a) Single, widowed, married, divorced 3
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased MARCH 30
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
68 10 24 hr. min.

9. Birthplace Osage, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Station Agent

11. Industry or business Telegrapher

12. Name JOSEPH LAGER

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

14. Maiden name UNKNOWN

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

16. (a) Informant Mrs. Catherine Cosma

(b) Address 1450 GLENN AVE

17. (a) Burial (b) Date thereof 1-28-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rest Home

18. (a) Signature of funeral director M. J. ...

(b) Address 7146 MANCHESTER

19. (a) Jan. 24, 1948 (b) Mrs. J. N. Moore
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 24
year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
that I last saw him alive on Jan 24 1948
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to aspiration

Due to Stop Breathing under Bed Room

Other conditions: _____
(Include pregnancy within 8 months of death)

Major findings: ventilated oil Circulator

Of operations _____

Of autopsy 182'

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(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? _____

While at work? _____ (Specify type of place)

(e) Means of injury Coroner

23. Signature David ... (M. D. or other) _____

Address ... Date signed 1/24/48

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

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

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 2/11/48
FEB 18 1948

FEB 6 1948

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 Kennedy
Licensed Embalmer No. 494
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.