No. 2
1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

35115

State File No. .....

FILED NOV 9 1948

Registration District No. 387

Primary Registration District No. 6076

Registrar's No. 2451

1. PLACE OF DEATH:

(a) County ST LOUIS

(b) City or town MANCHESTER, MO.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: MANCHESTER NURSING HOME 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 MO. 3 DAYS (Specify whether
In this community ..... years, months or days)

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. 5126a LEXINGTON AVE. 9
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No) 1

If yes, name country .....

3. (a) PRINT FULL NAME ANNA HAGEDORN

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex F 1

5. Color or race W

6. (a) Single, widowed, married, divorced WIDOW 2

6. (b) Name of husband or wife .....

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

7. Birth date of deceased JULY 27, 1852
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
96	2	25	..... hr. ..... min.

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

10. Usual occupation AT HOME

11. Industry or business .....

FATHER
12. Name AUGUST FENSKE
13. Birthplace GERMANY 4
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name ROSE MILCH
15. Birthplace GERMANY 4
(City, town, or county) (State or foreign country)

16. (a) Informant RUDOLPH SCHROEDER
(b) Address 5126a LEXINGTON AVE.

17. (a) REMOVAL (b) Date thereof 10-23-1948
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation PIERCE CITY MO.

18. (a) Signature of funeral director Wm. Schumacher
(b) Address 3013 Mesamer St

19. (a) 10-23-48 (b) Cecil A. Z. Gray M.D.
(Date received local registrar) (Registrar's signature) B.H.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT. day 22
year 1948 hour 3:45 minute P. M.

21. I hereby certify that I attended the deceased from Oct 19, 1948, to Oct 22, 1948
that I last saw her alive on Oct 22, 1948
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pneumonia	4 days
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 R B Denny (M. D. or other)

Address 7827 Delmar University City MO Date signed 10-23-48

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

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 Francis Williamson

Licensed Embalmer No. 3565

P. O. Address St Louis, Mo

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.

No. 2B
M—3-45
P I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Nov

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 2451

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Manchester
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

(d) Street No.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Anna Hagedorn

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 Wid

6. (b) Name of husband or wife

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

7. Birth date of deceased July (Month) 27 (Day) 1852 (Year)

8. AGE: Years 96 Months 2 Days 28 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 2 year 1948 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Lobar pneumonia	3 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

108

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 R B Denny (M. D. or other)
Address Date signed

SUPPLEMENTARY

S-35115