

FILED JAN 26 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2177

BIRTH NO. _____ REG. DIST. NO. 277 PRIMARY REG. DIST. NO. 5951 Registrar's No. 1

1. PLACE OF DEATH a. COUNTY PIKE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY PIKE	
b. CITY (If outside corporate limits, write RURAL and give township) INDIAN TWP		c. CITY (If outside corporate limits, write RURAL and give township) INDIAN TWP	
c. LENGTH OF STAY (in this place) 75 yrs		d. STREET ADDRESS (If rural, give location) 7 mi S.W. of CHERRYVILLE	
d. FULL NAME OF HOSPITAL OR INSTITUTION 7 mi S.W. of CHERRYVILLE			

3. NAME OF DECEASED (Type or Print) a. (First) JOHN	b. (Middle) REID	c. (Last) HAGAN	4. DATE OF DEATH (Month) (Day) (Year) JAN 9 1949
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5. SEX MALE	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, OR WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 9.23.1866	9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months 3 Days 20	IF UNDER 12 HRS. Hours Mins.
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10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) FARMER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) BOONE COUNTY MO	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME SMITH HAGAN	13b. MOTHER'S MAIDEN NAME MARTHA REID	14. NAME OF HUSBAND OR WIFE LONA HAGAN
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME H. S. Hagan Cherryville Mo	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 Weeks
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Influenza		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Myocarditis Anticoagulation Encephalitis			

19a. DATE OF OPERATION ✓	19b. MAJOR FINDINGS OF OPERATION ✓	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) ✓	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 481
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 19 ⁴¹ to 1-9, 19 ⁴⁹; that I last saw the deceased alive on 1-7, 19 ⁴⁹, and that death occurred at 8 P. m., from the causes and on the date stated above.

23a. SIGNATURE M. Mathews	(Degree or title)	23b. ADDRESS 254 N. Bow City Free Mo	23c. DATE SIGNED 1-13-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE JAN 11 1949	24c. NAME OF CEMETERY OR CREMATORY New Harmony Cemetery	24d. LOCATION (City, town, or county) (State) Pike County Missouri
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DATE REC'D BY LOCAL REG. 1-14-49	REGISTRAR'S SIGNATURE Bill Robinson	25. FUNERAL DIRECTOR'S SIGNATURE W. S. Staters	ADDRESS Vandalia Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 10

District File Number 1-22-132

Date Filed JAN 24 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed William B. Waters

Signed _____
Student Embalmer

Licensed Embalmer No. 4169

P. O. Address Sandwich, Mass.

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.