

FILED FEB 8 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 2262

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 284 PRIMARY REG. DIST. NO. 3056 Registrar's No. 26

1. PLACE OF DEATH a. COUNTY <u>RANDOLPH</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Randolph</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Moberly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Moberly 8<sup>th</sup></u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>905 Myra</u>		d. STREET ADDRESS (If rural, give location) <u>905 Myra</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Hester</u> b. (Middle) <u>ANN</u> c. (Last) <u>Hagar</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>1-27-49</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>5/1/1858</u>
9. AGE (In years last birthday) <u>90</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>26</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Wm P Jennings</u>	
13b. MOTHER'S MAIDEN NAME <u>Elizabeth Burnett</u>		14. NAME OF HUSBAND OR WIFE <u>Christopher C. Hagar</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Cora Davis</u>		ADDRESS <u>905 Myra Moberly Mo</u>	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage R. side</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arterio sclerosis &amp; hypertension</u> DUE TO (c) <u></u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>old Rheumatic Heart Disease</u>	
INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>		D.K. <u></u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>none 331X</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR			
22. I hereby certify that I attended the deceased from <u>Jan 24, 1949</u> , to <u>Jan 27, 1949</u> , that I last saw the deceased alive on <u>Jan 27, 1949</u> , and that death occurred at <u>10:35 a.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>W. Dreyer M.D.</u>		23b. ADDRESS <u>Huntsville Mo</u>	
23c. DATE SIGNED <u>1/28/49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>1-30-1949</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Huntsville</u>		24d. LOCATION (City, town, or county) (State) <u>Huntsville Mo</u>	
DATE REC'D BY LOCAL REG. <u>1-30-49</u>		REGISTRAR'S SIGNATURE <u>Leah Williams Lewis</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Sauve E. Dwyer</u>		ADDRESS <u>Huntsville Mo</u>	

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

RECEIVED

District Health Officer No. 10

District File Number 2-49-247

Date Filed FEB 7 - 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 Clarence E. Hopper

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 4761

P. O. Address Clarence, 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.