

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED AUG 11 1949

State File No. 24097

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

BIRTH NO. _____		REG. DIST. NO. 209		PRIMARY REG. DIST. NO. 3043		Registrar's No. 250		
1. PLACE OF DEATH a. COUNTY <u>Marion</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>				
b. CITY (If outside corporate limits, write RURAL and give township) <u>Hannibal</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <u>Hannibal</u>		BT 2 4		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Residence, 806 Butler</u>				d. STREET ADDRESS (If rural, give location) <u>806 Butler</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Ernest Martin</u> b. (Middle) _____ c. (Last) <u>Hagspihl</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 24, 1949</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>April 13, 1873</u>		
9. AGE (In years last birthday) <u>76</u>		IF UNDER 1 YEAR <u>3</u> Months		IF UNDER 12 HRS. <u>11</u> Hours		IF UNDER 15 MIN. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>I E Dupont Company</u>		11. BIRTHPLACE (State or foreign country) <u>Herford Westphalia Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>4</u>	
13a. FATHER'S NAME <u>Herman Hagspihl</u>			13b. MOTHER'S MAIDEN NAME <u>Johan M Stein</u>			14. NAME OF HUSBAND OR WIFE <u>Lorraine Hagspihl</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>E. Wesley Hagspihl</u> ADDRESS <u>Hannibal Missouri</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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>arteriosclerotic heart disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>4200</u> 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.				
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		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 1949</u> , to <u>July 24, 1949</u> , that I last saw the deceased alive on <u>July 23, 1949</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above.								
23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>MD</u>				23b. ADDRESS <u>Hannibal Mo</u>		23c. DATE SIGNED <u>July 27-49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7/27/1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet</u>		24d. LOCATION (City, town, or county) (State) <u>Hannibal Missouri</u>		
DATE REC'D BY LOCAL REG. <u>7-28-49</u>		REGISTRAR'S SIGNATURE <u>Dr. E. M. Lucke</u>		FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Hannibal Missouri</u>		

**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 \_\_\_\_\_

*John S. Ward*

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

Licensed Embalmer No. 1510

P. O. Address Hannibal Missouri

**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.