

FILED AUG 2 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25649

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>6076</u>		Registrar's No. <u>1806</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>1 year</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>CITY OF ST. LOUIS</u>		1-27-49	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Halls Ferry Memorial Home</u>				d. STREET ADDRESS (If rural, give location) <u>Halls Ferry Memorial Home</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Jacob</u> b. (Middle) _____ c. (Last) <u>Hager</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 6 1949</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>Never married</u>	8. DATE OF BIRTH <u>Unknown</u>		9. AGE (In years last birthday) <u>47</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet metal worker</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Moline, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Jacob Hager Sr.</u>		13b. MOTHER'S MAIDEN NAME <u>Emma Harris</u>		14. NAME OF HUSBAND OR WIFE _____			
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>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Dr. N. Shamer</u>			ADDRESS <u>2115 Pepper Drive</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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION						
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis</u>	INTERVAL BETWEEN ONSET AND DEATH _____						
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 checked="" 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) _____ m.		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>March 1, 1949</u> , to <u>July 6, 1949</u> , that I last saw the deceased alive on <u>July 6, 1949</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.							
23a. SIGNATURE <u>N. Shamer M.D.</u> (Degree or title)				23b. ADDRESS <u>2739 - N. Grand</u>		23c. DATE SIGNED <u>7-6-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>July 8, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Moline Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Moline, Illinois</u>		
DATE REC'D BY LOCAL REG. <u>7-9-49</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Wozke Md</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ball-Campbell Mortuary</u> ADDRESS <u>4715 Lombard St.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

D. 48

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 Ray E Campbell

Signed.....
Student Embalmer

Licensed Embalmer No. 3881

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.