

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21852

State File No.

FILED JUN 29 1956

318

1003

5782

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY				
b. CITY (If outside corporate limits, write RURAL and give town or township) St. Louis		c. LENGTH OF STAY (in this place) 2 days		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Lukes Hospital				STREET ADDRESS (If rural, give location) 1609 Grape Avenue		206 1/2		
3. NAME OF DECEASED (Type or Print) a. (First) Louis b. (Middle) C c. (Last) Haagen			4. DATE OF DEATH (Month) (Day) (Year) June 17 1956					
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widower		8. DATE OF BIRTH May 18, 1865		
9. AGE (In years last birthday) 91		IF UNDER 1 YEAR Months Days		IF UNDER 18 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician (MD)			10b. KIND OF BUSINESS OR INDUSTRY Retired			11. BIRTHPLACE (City and State or Foreign Country) Germany		
12. CITIZEN OF WHAT COUNTRY? USA			13a. FATHER'S NAME Frederick Haagen		13b. MOTHER'S MAIDEN NAME ----- Klundt		14. NAME OF HUSBAND OR WIFE Elizabeth M. Haagen (Deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknowns) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Miss Eugenia Haagen, 1609 Grape Avenue				
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>Cardiac failure</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic cardiovascular dis.</u> DUE TO (c) <u>Volvelus of trans colon c surgery</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Broncho pneumonia, treated, 24 hrs?</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>indef.</u> <u>24-48 hrs.</u>		
19a. DATE OF OPERATION <u>June 16, 1956</u>		19b. MAJOR FINDINGS OF OPERATION <u>Volvelus of transverse colon - Dr. Alan McAlfee, 1007 Euclid</u>				20. AUTOPSY? YES <input checked="" 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) <u>5703</u>				
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? <u>#22 +</u>				
22. I hereby certify that I attended the deceased from <u>approx. 1948</u> , to <u>June 17, 1956</u> , that I last saw the deceased alive on <u>June 17, 1956</u> , and that death occurred at <u>10:30A</u> m., from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>Harold R. McAlfee, MD</u>				23b. ADDRESS <u>4110 Neil Floissant Ave.</u>		23c. DATE SIGNED <u>June 18, 1956</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE June 20 1956		24c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County Missouri		
DATE REC'D BY LOCAL REG. JUN 18 1956		REGISTRAR'S SIGNATURE <u>Carl Smith MD</u> m&B		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Math Hermann & Son, Inc., 2161 E. Fair Av				

(Licensed Embalmer's Statement on Reverse Side)

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

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..

Student.....
Signature of Student Embalmer

Signed *Clarence T. McNeary*

Licensed Embalmer No. *373*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.