

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39883
STATE FILE NUMBER

FILED NOV 25 1957

Registration District No. 118 Primary Registration District No. 4188 Registrar's No. 36

V. S. 300
Rev. 1-57

1. PLACE OF DEATH a. COUNTY Gasconade		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE Mo. b. COUNTY Gasconade)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Owensville		c. CITY OR TOWN Owensville	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 112 South Second		d. STREET ADDRESS (If outside, give location) 112 South Second	
3. NAME OF DECEASED (Type or print) First Middle Last EVA AGNES LAGEMANN		4. DATE OF DEATH Month Day Year 11 12 1957	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22 1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Owensville, Mo.
13a. FATHER'S NAME Charles Matthews		13b. MOTHER'S MAIDEN NAME Laura Biles	14. NAME OF HUSBAND OR WIFE Harry W. Lagemann
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 491 18 0184	17. INFORMANT Address Edward Koch Owensville Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right Hemiplegia DUE TO (b) Cerebral Hemorrhage Due To Hypertension DUE TO (c) 331X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) : Arteriosclerotic Heart Disease.			INTERVAL BETWEEN ONSET AND DEATH 2 weeks 3 years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 10-31-57 to 11-12-57 and last saw her alive on 11-11-57 . Death occurred at 7:35 A. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Parsons Brunner, M.D. (Degree or title)		22b. ADDRESS Owensville, Mo.	
		22c. DATE SIGNED 11-14-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-15-1957	
23c. NAME OF CEMETERY OR CREMATORY City Cemetery		23d. LOCATION (City, town, or county) (State) Owensville, Mo.	
24. FUNERAL DIRECTOR Missed N/H Winter OWENSVILLE		25. DATE RECD. BY LOCAL REG. November 15, 1957	
		26. REGISTRAR'S SIGNATURE Mrs. Marjorie Jappmeyer	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

DEC 9 1957

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 me....., Student Embalmer No. working under my personal-supervision.

Student
Signature of Student Embalmer

Signed Myford H H Winter.....

Licensed Embalmer No. 3238.....

P. O. Address OWENSVILLE.....

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.