

FILED FEB 10 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

921  
STATE FILE NUMBER  
97B

Registration District No. 128 Primary Registration District No. 2000 Registrar's No.

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield,</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Springfield,</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Ozark Osteopathic Hospital</b>		Length of stay in 1b <b>8 days</b>	d. STREET ADDRESS (If outside, give location) <b>2138 N. Main</b>
3. NAME OF DECEASED (Type or print) First <b>Dona</b> Middle <b>Magnola</b> Last <b>Hager</b>			4. DATE OF DEATH Month <b>January</b> Day <b>27</b> Year <b>1958</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/13/1888</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>69</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) <b>Polk County, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Heed Potts</b>		13b. MOTHER'S MAIDEN NAME <b>Effie Kirby</b>	14. NAME OF HUSBAND OR WIFE <b>Lewis Hager</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT Address <b>Mrs. A.B. Morris, 1808 W. Walnut, Springfield</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>			INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Chronic Myocarditis</b>			<b>6 weeks</b>
DUE TO (c) <b>Auricular Fibrillation</b>			<b>2 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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 WORK <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 Death occurred at <b>6:25 P.M.</b> <b>1945</b> to <b>1/27/58</b> and last saw her alive on <b>1/27/58</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>William Simpson, M.D.</b>		22b. ADDRESS <b>Landers Building Springfield, Missouri</b>	22c. DATE SIGNED <b>1/27/58</b>
23a. BURIAL, CREMATION, REMOVAL, (Specify)	23b. DATE <b>Jan. 30, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mitchell Camp Ground</b>	23d. LOCATION (City, town, or county) (State) <b>Polk County, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Robt. Thiem, Springfield, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>2-4-58</b>	26. REGISTRAR'S SIGNATURE <b>Effie G. Melton</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Lee Mason* .....

Licensed Embalmer No. *4568*  
P. O. Address *Springfield*

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.