

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022996

STATE FILE NUMBER

2 6123

FILED JUL 13 1959 Registration District No. _____ Primary Registration District No. _____ Registrar No. 6123

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6249 Loran Ave		d. STREET ADDRESS (If outside, give location) 6249 Loran Ave	
Length of stay in lb		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WALTER HARVEY HOAGLAND			4. DATE OF DEATH Month Day Year 6-27-1959
5. SEX Male	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 2-11-1883
9. AGE (In years and birthday) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk	11. BIRTHPLACE (City and state or country) Illinois
10b. KIND OF BUSINESS OR INDUSTRY Outdoor Adv. Co		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME John B. Hoagland		13b. MOTHER'S MAIDEN NAME Delia Spruill	14. NAME OF HUSBAND OR WIFE Lillian Hoagland
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 490-01-9911	17. INFORMANT Lillian Hoagland Address 6249 Loran Ave
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Vascular Accident DUE TO (c) Cerebral Embolus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 3324			INTERVAL BETWEEN ONSET AND DEATH 2 wks. 5 yrs. 5 yrs.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 WORK 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 June 1954 to June 27 1959 and last saw him alive on June 17, 1959 Death occurred at 6:15 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE H. Benjamin M.D.		22b. ADDRESS 7430 Virginia Ave.	
22c. DATE SIGNED 6/28/59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	
23c. DATE 6-30-1959		23d. LOCATION (City, town, or county) (State) 10160 Gravois Road Mo	
24. FUNERAL DIRECTOR Diegenheim Bros		25. DATE RECD. BY LOCAL REG. JUN 29 1959	
ADDRESS 6409 Gravois Av		26. REGISTRAR'S SIGNATURE Loan Smith, M.D.	

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

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 *Van M. Sezenov*

Licensed Embalmer No. *434*

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.