

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4389 STATE FILE NUMBER

FILED MAY 19 1961

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY | |
| b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> | | c. CITY OR TOWN <u>St. Louis</u> | |
| Length of stay in 1b | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>5314 Oriole Ave.</u> | | d. STREET ADDRESS (If outside, give location) <u>5314 Oriole Ave.</u> | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First Middle Last <u>KATIE HAGEDORN</u> | 4. DATE OF DEATH Month Day Year <u>May 6 1961</u> |
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| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>4/27/1883</u> | 9. AGE (last birthday) <u>78</u> | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | 11. BIRTHPLACE (City and state or country) <u>Poland</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>Unknown</u> | 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | 14. NAME OF HUSBAND OR WIFE <u>Franke Hagedorn</u> |
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| 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. <u>None</u> | 17. INFORMANT <u>Franke Hagedorn 5314 Oriole Ave.</u> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH YEARS |
| IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE WITH MYOCARDIAL ISCHEMIA.</u> | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) | |
| | DUE TO (c) | <u>420.0</u> |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 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.) |
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| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | 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 |
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| 21. I attended the deceased from <u>5/1/61</u> to <u>5/6/61</u> and last saw her <u>alive</u> on <u>5/4/61</u> Death occurred at <u>5/6/61 4:40 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE (Degree or title) <u>Joseph A. Costello M.D.</u> | 22b. ADDRESS <u>2425 N. BROADWAY, ST. LOUIS 8, MO.</u> | 22c. DATE SIGNED <u>5/8/61</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>5/10/1961</u> | 23c. NAME OF GEMETERY OR CREMATORY <u>Calvary Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u> |
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| 24. FUNERAL DIRECTOR <u>JOHN STYGAR & SON - 5541 DIVERDREW</u> | 25. DATE RECD. BY LOCAL REG. <u>MAY 9 1961</u> | 26. REGISTRAR'S SIGNATURE <u>Neal Smith M.D.</u> |
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 J. M. Rister

Licensed Embalmer No. 3980

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.