

NOV 13 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

33938  
Do not use this space.

1003

1. PLACE OF DEATH

(a) County ..... Registration District No. ....  
(b) Township ..... Primary Registration District No. .... Registered No. **8476**  
(c) City St. Louis, Mo (d) Street No. Firmin Desloge Hospital St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Sharon Rose Hagberg 216  
(a) Residence, No. 9543 Hawthorne St. **WR** Overland Mo  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female  
4. COLOR OR RACE W  
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) \_\_\_\_\_  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 30, 1939  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, 8 hrs. or 10 min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_  
11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) Firmin Desloge Hospital  
(STATE OR COUNTRY) St. Louis Mo

13. NAME Kenneth Hagberg

14. BIRTHPLACE (CITY OR TOWN) Carlwright  
(STATE OR COUNTRY) N. Dakota

15. MAIDEN NAME Lillian Wlodarek

16. BIRTHPLACE (CITY OR TOWN) St. Louis  
(STATE OR COUNTRY)

17. INFORMANT Father Kenneth Hagberg  
(ADDRESS) 9543 Hawthorne Ave, Overland Mo

18. BURIAL, CREMATION, OR REMOVAL  
PLACE St. Louis DATE 9-30-39

19. FUNERAL DIRECTOR (NAME) W. Richter  
(ADDRESS) 3500 Rutgers

20. FILED OCT 3 1939

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 30, 1939  
22. I HEREBY CERTIFY, That I attended deceased from 10 am June 30, 1939, to 6:30 pm June 30, 1939  
I last saw h. ex. alive on June 30, 1939. Death is said to have occurred on the date stated above, at 6:30 p.m.  
The principal cause of death and related causes of importance were as follows:

INTRA CRANIAL HEMORRHAGE Date of onset \_\_\_\_\_

Other contributory causes of importance: \_\_\_\_\_  
Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_  
(Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?  
If so, specify \_\_\_\_\_  
(Signed) George A. Mitchell, M. D.  
(Address) 1325 S. Grand

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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 this body is not embalmed, above space should be left blank.**