

V. S. No. 2
M-11-10-39
5-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 5983
Registrar's No. 184

FILED MAR 11 1940

Registration District No. 85

Primary Registration District No. 1001

11
57

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3004 Olive St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 20 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Buchanan
(c) City or town St. Joseph, Mo.
(If outside city or town limit, write "RURAL")
(d) Street No. 3004 Olive St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME JOSEPH G. HAGER

3. (b) If veteran, name war _____ (c) Social Security No. _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 11th, 1862
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>77</u>	<u>7</u>	<u>5</u>	hr. _____ min.

9. Birthplace (unk) W. Virginia
(City, town, or county) (State or foreign country)

10. Usual occupation ex. Park Board employee

11. Industry or business

MOTHER FATHER { 12. Name Joseph Hager
13. Birthplace unknown Germany
(City, town, or county) (State or foreign country)
14. Maiden name Haden
15. Birthplace unknown Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. William Wallace

(b) Address St. Joseph, Mo.

17. (a) burial (b) Date thereof 2/18/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director ELEEMAN & SON INC.

(b) Address 1946 Calhoun St. Joseph

19. (a) Feb. 16, 1940 (b) A. J. Westbush
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 16th
year 1940 hour 1 minute 15 A.M.

21. I hereby certify that I attended the deceased from am, 1936, to Feb 16, 1940
that I last saw him alive on Feb. 16, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Ch
Duration 4m

Due to Art. Scler. + Hypertension
gradually ending suddenly with
Due to coronary occlusion

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations ✓

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature [Signature] (M. D. or other) !
Address St. Joseph, Mo Date signed 2-16-40

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. 4082

P. O. Address St Joseph

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.