

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Missouri Baptist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96

(c) City or town Lemay Rural P
(If outside city or town limits, write "RURAL")

(d) Street No. Route 9 Box 644
(If rural, give location)

(e) Citizen of foreign country? no / (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Carrie Hagemann

(b) If veteran, name war. no

(c) Social Security No. None

4. Sex Female / 5. Color or race White

6. (a) Single, widowed, married, divorced Married

(b) Name of husband or wife George Hagemann

(c) Age of husband or wife if alive 59 years

7. Birth date of deceased June 30 1876
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

68 9 4 _____ hr. _____ min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name of father George Rubel

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Marga ret Nagengast

15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant George Hagemann
(b) Address Rt. 9 Lemay, Mo.

17. (a) Burial (b) Date thereof April 7, 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director C. Hoffmeister U. & L. Co.
(b) Address 7814 S. Broadway

19. (a) APR 4 1945 (b) J. F. Budeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 3
year 1945 hour 7 minute 56 P. A. M.

21. I hereby certify that I attended the deceased from March 27 - 1945 to April - 3 - 1945
that I last saw her alive on Apr - 3 - 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Suppression of Urine Duration 3 days

Due to Pressure from Large Carcinoma of Left Ovary 1 yr

Due to _____

Other conditions (Include pregnancy within 3 months of death) HA

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: _____

Of operations: _____

Of autopsy: _____

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)

Means of injury _____

23. Signature Beulah H. Smith (M. D. or other) M.D.
Address 220 - 21 - 4th St. St. Louis Date signed 4/4/45

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

MOTHER FATHER

Dr. Shutt 220 N. 4th St.

about 2 PM

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 *Louis C. Hoffmeister*

Licensed Embalmer No. *3871*

P. O. Address *7814 S. Broadway*

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, fact should be so stated above.