S. No. 2
M—8-43
5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

18099

State File No. d

FILED JUN 11 1945

Registration District No. 3[illegible]

Primary Registration District No. 3063

Registrar's No. 1205

1. PLACE OF DEATH:

(a) County St Louis

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

(c) Name of hospital or institution: St Louis County Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 hours (Specify whether

In this community ——
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis Mo

(c) City or town St Louis Missouri
(If outside city or town limits, write "RURAL")

(d) Street No. 2838 Arlington
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Haggenjos, William

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife Agnes Haggenjos

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

7. Birth date of deceased 2 (Month) 22 (Day) 1869 (Year)

8. AGE:	Years	Months	Days	If less than one day
	76	3	—	hr. min.

9. Birthplace St Louis (City, town, or county) Mo (State or foreign country) 0

10. Usual occupation Retired

11. Industry or business —

FATHER
12. Name Wm Haggenjos
13. Birthplace unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Mary
15. Birthplace unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant son Wm Haggenjos

(b) Address 7054 Natural Bridge

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 25/45. (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.,

18. (a) Signature of funeral director Jos. W. Clark

(b) Address 1125 Hodiamont Ave.,

19. (a) MAY 24 1945 (Date received local registrar) (b) E. E. McGowran MD (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month 5 day 22 year 1945 hour 8 05 minute A M.

21. I hereby certify that I attended the deceased from 5 22, 1945, to 5-22, 1945; that I last saw him alive on 5/22, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulmonary oedema	2
Due to Arteriosclerotic heart disease	2
Due to 93d	
Other conditions Chronic urinary retention due to prostatic hypertrophy (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? (Specify type of place)

While at work? (e) Means of injury 0

23. Signature Robert J Meagher (M. D. or other) MD

Address 601 Brentwood Date signed 5/22/45

(Licensed Embalmer's Statement on Reverse Side) Clayton

SEP 18 1945

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 Alan J. Neely

Licensed Embalmer No. 3225-1

P. O. Address 1125 Hodiamont Ave

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.