

FILED NOV 22 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **36294**

BIRTH NO. _____		REG. DIST. NO. <b>43</b>		PRIMARY REG. DIST. NO. <b>3007</b>		Registrar's No. <b>437</b>		
1. PLACE OF DEATH a. COUNTY <b>Butler</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Stoddard</b> 1090				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Roplar Bluff</b>		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural Castor</b>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Doctors Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>Bloomfield, Route # 2.</b>				
3. NAME OF DECEASED (Type or Print) a. (First) <b>Laudis</b> b. (Middle) <b>Oneal</b> c. (Last) <b>Hager</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 10, 1950</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Sept. 29, 1914</b>		
9. AGE (In years last birthday) <b>36</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>11</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>Madon Mississippi</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Henry Lone</b>			13b. MOTHER'S MAIDEN NAME <b>Not known</b>			14. NAME OF HUSBAND <b>R. A. Hager</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>R. A. Hager-Bloomfield, Mo. R. # 2</b>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		<p align="center"><b>MEDICAL CERTIFICATION</b></p> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Intestinal Obstruction</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Postoperative Adhesions</b> DUE TO (c) <b>Dyspension Uterus</b>					INTERVAL BETWEEN ONSET AND DEATH          <b>5705</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <b>11-3-</b> , 19 <b>50</b> , to <b>11-10-</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>11-10-</b> , 19 <b>50</b> , and that death occurred at <b>10:40</b> a.m., from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <b>J. B. Johnson</b>				23b. ADDRESS		23c. DATE SIGNED <b>11-17-50</b>		
24a. BURIAL-CREMATATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Nov. 12-50</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Charleston cem.</b>		24d. LOCATION (City, town, or county) (State) <b>Charleston, Missouri</b>		
DATE REC'D BY LOCAL REG. <b>Nov. 18-1950</b>		REGISTRAR'S SIGNATURE <b>Wm H. Johnson</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>CHILES UND. CO. Bloomfield, Mo. &amp; WELCH FUNERAL HOME, Sikeston, Mo.</b>				

(Licensed Embalmer's Statement) WELCH FUNERAL HOME, Sikeston, Mo.

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

