

FILED JUN 24 1954

THE DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

20568

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>5168</u>			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>2181</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST Louis</u>		c. LENGTH OF STAY (In this place) <u>1</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST Louis</u>		d. STREET ADDRESS (If rural, give location) <u>18 3420 Laclede</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3420 Laclede</u>				d. STREET ADDRESS (If rural, give location) <u>18 3420 Laclede</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Luther</u>			b. (Middle) _____		c. (Last) <u>Hagans</u>		4. DATE OF DEATH (Month) <u>6</u> (Day) <u>8</u> (Year) <u>54</u>		
5. SEX <u>Male 2</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married 1</u>		8. DATE OF BIRTH <u>1-13-13</u>		9. AGE (In years last birthday) <u>41</u> If under 1 year: Months _____ Days _____ If under 24 hrs. Hours _____ Mins. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Paper Stock Co. - laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>WYNNARK, 1</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <u>Will Hagan</u>			13b. MOTHER'S MAIDEN NAME <u>Lillian Smith</u>			14. NAME OF HUSBAND OR WIFE <u>LILY MAY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>WW # 2</u>			16. SOCIAL SECURITY NO. <u>430-07-2639</u>		17. INFORMANT'S SIGNATURE OR NAME <u>LILY MAY HAGANS</u>			ADDRESS <u>3420-Laclede</u>	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES <u>Carotid Arteriosclerosis</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____					20. AUTOPSY? YES <input checked="" 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? <u>4201</u>				
22. I hereby certify that I attended the deceased from <u>3</u> , 19 <u>54</u> , to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>5:00</u> p.m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>James M. Kelly Deputy Coroner 1300</u>				23b. ADDRESS <u>Clark</u>			23c. DATE SIGNED <u>6/10/54</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Re burial</u>		24b. DATE <u>6-10-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>National</u>		24d. LOCATION (City, town, or county) (State) <u>Jefferson Barracks MO</u>			
DATE REC'D BY LOCAL REG. <u>JUN 10 1954</u>		REGISTRAR'S SIGNATURE <u>Carl Smith MO Whitten + Smith</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>mss</u>		ADDRESS <u>4374 Washington</u>		

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING BLACK INK—MAKE A PERMANENT RECORD

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Ald

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.