

Health,
Welfare
Public
Service

FILED OCT 2 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33111
STATE FILE NUMBER
Registration District No. 314 Primary Registration District No. 4408 Registrar's No. 50

300
1-57

1. PLACE OF DEATH a. COUNTY ST CLAIR		2. USUAL RESIDENCE (Where deceased lived. If institution? Residence before admission) a. STATE Mo b. COUNTY ST CLAIR	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Collins		c. CITY OR TOWN Collins	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location) 9th St	
Length of stay in 1b		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First FRANK Middle J. Last HAGAN			4. DATE OF DEATH Month Sep Day 6 Year 1957		
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5. SEX M	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 7. 1881	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DETECTIVE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Colorado	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Frank H. Hagan	13b. MOTHER'S MAIDEN NAME Julia Sheek	14. NAME OF HUSBAND OR WIFE —
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. NONE	17. INFORMANT Sue Hagan-Collins	Address MO
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Nephritis		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 592x		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from 5-9-57 to 9-6-57 and last saw her alive on 9-6-57 Death occurred at 2:40 PM on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) D. E. D. Brown, Do	22b. ADDRESS Collins Mo	22c. DATE SIGNED 9-7-57
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-8-57	23c. NAME OF CEMETERY OR CREMATORY HUMANSVILLE	23d. LOCATION (City, town, or county) (State) HUMANSVILLE MO
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24. FUNERAL DIRECTOR Goodrich & NOME	ADDRESS OSCEOLA MO	25. DATE RECD. BY LOCAL REG. 9-10-57	26. REGISTRAR'S SIGNATURE Ruth Seewer
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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
Signature of Student Embalmer

Signed *J B Eudick*

Licensed Embalmer No. *3038*

P. O. Address *Orlando Fla*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.