

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS MAR 3 0 1960**

**60-013496**

Registration District No. **317** Primary Registration District No. **548** Registrar's No. **958** STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Louis</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Webster Groves</b> Length of stay in lb c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>832 Clark</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b> c. CITY OR TOWN <b>Webster Groves</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>832 Clark</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First <b>ERNEST</b> Middle <b>HENRY</b> Last <b>DAGGER</b>				<b>4. DATE OF DEATH</b> Month <b>Mch.</b> Day <b>20,</b> Year <b>1960</b>											
<b>5. SEX</b> <b>M</b>		<b>6. COLOR OR RACE</b> <b>W</b>		<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>4-22-1884</b>		<b>9. AGE (last birthday)</b> <b>75</b>		<b>IF UNDER 1 YEAR</b> Months Days Hours Min. <b>IF UNDER 24 HR</b>					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Office Mgr. Retired</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>S.W. Bell Tel. Co.</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Yoevil England</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>							
<b>13a. FATHER'S NAME</b> <b>Henry Dagger</b>				<b>13b. MOTHER'S MAIDEN NAME</b> <b>Annie Cook</b>				<b>14. NAME OF HUSBAND OR WIFE</b> <b>Emelie Dagger</b>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>488-10-4076</b>		<b>17. INFORMANT</b> <b>Mrs. E.H. Dagger</b> Address <b>832 Clark</b>									
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> DUE TO (b) <b>INCREASED INTRACRANIAL PRESSURE</b> DUE TO (c) <b>GLIOBLASTOMA MULTIFORME, BRAIN</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown										INTERVAL BETWEEN ONSET AND DEATH <b>1 HR.</b> <b>1 Mo.</b> <b>8 Mo.</b>					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)											
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE	
<b>21. I attended the deceased from</b> <b>Aug 1959</b> to <b>Mar 20, 1960</b> and last saw him alive on <b>Mar 20, 1960</b> Death occurred at <b>8:00 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.															
<b>22a. SIGNATURE</b> (Degree or title) <b>Thompson M.D.</b>						<b>22b. ADDRESS</b> <b>St. Louis 19, Mo.</b>				<b>22c. DATE SIGNED</b> <b>3/21/60</b>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE</b> <b>3-22-1960</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Oak Hill Cemetery</b>				<b>23d. LOCATION</b> (City, town, or county) <b>Kirkwood Mo</b> (State)							
<b>24. FUNERAL DIRECTOR</b> <b>Parker-Aldrich Webster Groves Mo.</b> ADDRESS						<b>25. DATE RECD. BY LOCAL REG.</b> <b>MAR 21 1960</b>		<b>26. REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Leslie Holch

Licensed Embalmer No. 439  
P. O. Address Holcher 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.