

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-004175

FILED VS FEB 14 1961

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 379

STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JEFFERSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>JEFFERSON BARRACKS, MO.</b> Length of stay in lb <b>32 DAYS</b>		c. CITY OR TOWN <b>FESTUS</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>R. F. D NO 1</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ARTHUR P. HAGBERG</b>			4. DATE OF DEATH Month Day Year <b>2-6-61</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-26-94</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOSPITAL ATTENDANT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOSPITAL</b>	9. AGE (last birthday) <b>66</b>
11a. FATHER'S NAME <b>JOHN HAGBERG</b>		11b. MOTHER'S MAIDEN NAME <b>JOSEPHINE ANDERSON</b>	11. BIRTHPLACE (City and state or country) <b>DOE RUN, MISSOURI</b>
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WW-1</b>		12b. SOCIAL SECURITY NO.	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		14. NAME OF HUSBAND OR WIFE <b>MRS. ANNA FREESE, RFD #1, FESTUS, MO.</b>	
IMMEDIATE CAUSE (a) <b>CEREBRAL INFARCTION</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>CEREBRAL ARTERIOSCLEROSIS</b>		<b>UNDET.</b>	
DUE TO (c)		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	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)	
20c. TIME OF INJURY. Hour a.m. p.m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <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
21. I attended the deceased from <b>1-5-61</b> to <b>2-6-61</b> and last seen alive on <b>2-6-61</b> at <b>7:50</b> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>FRED IONATA</b>		22b. ADDRESS <b>M.D. VA HOSP. JEFF. BRKS. MO.</b>	22c. DATE SIGNED <b>2-6-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<b>Entombment Feb 9, 1961</b>	<b>Local Mausoleum</b>	<b>Minneapolis, Minn.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Vinyard Funeral Home, Festus, Mo</b>		25. DATE RECD. BY LOCAL REG. <b>2-7-61</b>	26. REGISTRAR'S SIGNATURE <b>John C. Muffly M.D.</b>

FEB 15 1961

**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 *Al W. Ungard*

Licensed Embalmer No. 3010

P. O. Address *Fester W O*

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.