

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-001205

STATE FILE NUMBER

Registration District No. 149

Primary Registration District No. 1.002 Registrar's No. 262

AMENDED

FILED JAN 25 1962

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 22 yrs.	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION McCarty Nursing Home 3621 Warwick		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4715 Belleview Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First WILLIAM Middle HAGSTROM Last HAGSTROM			4. DATE OF DEATH Month January Day 15 Year 1962		
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5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-15-1876	9. AGE (last birthday) 85	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner, Hagstrom Manufacturing Co., K.C., Mo.		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Lindsborg, Kansas	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Axel Hagstrom	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Minnie Hagstrom
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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. - - - - -	17. INFORMANT Paul E. Hagstrom Address 4715 Belleview
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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) Carcinoma of the Rectum		INTERVAL BETWEEN ONSET AND DEATH 5 years
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). Arteriosclerosis, generalized		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
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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. - p.m. -	Month, Day, Year
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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 Lindsborg, Kansas	COUNTY Jackson	STATE Missouri
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21. I attended the deceased from **Aug. 1956** to **Jan. 15 '62** and last saw him alive on **Jan. 15 1962**
Death occurred at **1:15 p** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deceased or title) W. H. Sleat, M.D.	22b. ADDRESS 4620 Nichols Pky. Kansas City, Mo.	22c. DATE SIGNED 1-15-62
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1-15-62	23c. NAME OF CEMETERY OR CREMATORY -	23d. LOCATION (city, town, or county) (State) Lindsborg, Kansas
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24. FUNERAL DIRECTOR Freeman Mortuary ADDRESS Kansas City, Mo.	25. DATE RECD. BY LOCAL REG. 1-16-62	26. REGISTRAR'S SIGNATURE Ruth Long
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DATE AMENDED

 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

 INSTEAD OF

 DOCUMENT

 MEDICAL CERTIFICATION

 W. H. Sleat

 BY AFFIDAVIT OF

 ITEM NO. SHOULD READ

*Dr W. A. Slentz
4620 J. C. Nichols Hwy
2130-56 in
L 01-3500*

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. W. Johnson*

Licensed Embalmer No. 2939

P. O. Address F. O. Mo.

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.