

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-027014  
STATE FILE NUMBER  
7363

FILED AUG 1 1958

Registration District No.

318 Primary Registration District No. 1003

Registrar's No.

300  
1-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		Length of stay in lb <u>2079</u>	d. STREET ADDRESS <u>5444 Beacon Avenue</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARTIN HENRY HAGAN</u>			4. DATE OF DEATH Month Day Year <u>JULY 25, 1958</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 9, 1903</u>	9. AGE (In years last birthday) <u>55</u>	10. FUNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Barton Pontiac</u>		11. BIRTHPLACE (City and state or country) <u>Perryville, Mo.</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Lawrence Hagan</u>		13b. MOTHER'S MAIDEN NAME <u>Rose Endres</u>		
14. NAME OF HUSBAND OR WIFE <u>Irene Hagan</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no none</u>				
16. SOCIAL SECURITY NO. <u>488-03-5299</u>		17. INFORMANT Address <u>Mrs. Irene Hagan 5444 Beacon Avenue.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SEVERE AORTIC STENOSIS</u>					INTERVAL BETWEEN ONSET AND DEATH YEARS	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>SEVERE ARTERIOSCLEROTIC HEART DISEASE</u>					YEARS	
DUE TO (c) <u>420.0</u>						
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 Month, Day, Year a.m. p.m.						
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <u>JUNE 14, 1958</u> to <u>JULY 25, 1958</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>JULY 15, 1958</u> Death occurred at <u>7:18 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>C. D. Vermillion, M.D.</u> (Degree or title)			22b. ADDRESS <u>BARNES HOSPITAL</u>		22c. DATE SIGNED <u>7/26/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7/29/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri.</u>	
24. FUNERAL DIRECTOR <u>JOHN STYGAR &amp; SON - 5541 RIVERVIEW BLVD</u>		25. DATE RECD. BY LOCAL REC. <u>JUL 28 1958</u>		26. REGISTRAR'S SIGNATURE <u>J. Carl Smith, M.D.</u> S. P.		

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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. Rister* .....

Licensed Embalmer No. *3980* .....  
P. O. Address *St. Louis, 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.