No. 1
5-42
17-39
X32873

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

43074
State File No.

JAN 10 1944
Registration District No. 210

Primary Registration District No. 5776

Registrar's No. 177

1. PLACE OF DEATH:

(a) County Mercer

(b) City or town Rural Washington Township
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution
(Specify whether
In this community 6 mo
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County Decatur

(c) City or town Pleasanton
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country 2

3. (a) PRINT FULL NAME James Robert Hagan

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Anna Hagan

6. (c) Age of husband or wife if alive years

7. Birth date of deceased March (Month) 13 (Day) 1859 (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 20
year 1943 hour 3 minute 30 P.M.

21. I hereby certify that I attended the deceased from Dec - 5/43
Dec 19, 19, to Dec - 19, 1943
that I last saw him alive on Dec 19, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pneumonia	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause to which death should be charged statistically.

	Years	Months	Days	If less than one day
8. AGE:	84	9	7	hr. min.

9. Birthplace Harrison Co. (City, town, or county) Mo (State or foreign country)

10. Usual occupation Farmer

11. Industry or business /

MOTHER / FATHER

12. Name James R. Hagan

13. Birthplace (City, town, or county) Kentucky (State or foreign country)

14. Maiden name Mary Montgomery

15. Birthplace (City, town, or county) Kentucky (State or foreign country)

16. (a) Informant Clara Frabie

(b) Address Mill Grove Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 23 1943 (Month) (Day) (Year)

(c) Place: burial or cremation Leon Cem Leon Iowa

18. (a) Signature of funeral director Schooler Funeral Home

(b) Address Spickard Mo.

19. (a) 12-29-43 (Date received local registrar) (b) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature E W Ewing (M. D. or other)

Address Spickard Mo Date signed 12/20/43

1117 (Licensed Embalmer's Statement on Reverse Side)

MAR 23 1945

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed... Ross Kise

Licensed Embalmer No. 377

P. O. Address Spickard 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 this body is not embalmed, fact should be so stated above.

. No. 2B
—5-43
I X36930

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Jan.

Registration District No. ____ Primary Registration District No. ____ Registrar's No. ____

1. PLACE OF DEATH:
(a) County Mercer
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community ____

2. USUAL RESIDENCE OF DECEASED:
(a) State ____ (b) County ____
(c) City or town ____ (If outside city or town limits, write "RURAL")
(d) Street No. ____ (If rural, give location)
(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME James R. Hagan
3. (b) If veteran, name war ____
3. (c) Social Security No. ____

4. Sex M | 5. Color or race W | 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife ____ 6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased Mar. (Month) 13- (Day) 1859 (Year)

8. AGE: Years 84 | Months 9 | Days ____ | If less than one day ____ hr. ____ min.

9. Birthplace ____ (City, town, or county) Mo. (State or foreign country)

10. Usual occupation ____

11. Industry or business ____

MOTHER FATHER
12. Name ____
13. Birthplace ____ (City, town, or county) ____ (State or foreign country)
MOTHER
14. Maiden name ____
15. Birthplace ____ (City, town, or county) ____ (State or foreign country)

16. (a) Informant ____
(b) Address ____

17. (a) ____ (Burial, cremation, or removal) (b) Date thereof ____ (Month) (Day) (Year)
(c) Place: burial or cremation ____

18. (a) Signature of funeral director ____
(b) Address ____

19. (a) ____ (Date received local registrar) (b) ____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. Day 30
year 1943 hour ____ minute ____ M.

21. I hereby certify that I attended the deceased from ____, 19__ to ____, 19__;
that I last saw h__ alive on ____, 19__;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchial Pneumonia	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) 107	

Major findings:
Of operations ____
Of autopsy ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ____
(b) Date of occurrence ____
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? ____ (e) Means of injury ____

23. Signature E W Ewing (M. D. ~~or other~~)
Address Spickard Date signed 1-17-44

SUPPLEMENTARY

S-413074