

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **29642**

Primary Registration District No. **1000**

Registrar's No. **805**

FILE NUMBER **0025938**

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 **5117**

2 **5117**

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF **S.C. Benson, M.D.** MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph	
Length of stay in lb Life		Inside Limits Yes ☒ No ☐	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hospital		d. STREET ADDRESS (If outside, give location) 2312 Messanie	
3. NAME OF DECEASED (Type or print) First GEORGE Middle HENRY Last HAGER		4. DATE OF DEATH Month July Day 26 Year 1964	
5. SEX Male	6. COLOR OR RACE White	7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐	8. DATE OF BIRTH 12-16-1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Plumber & Steamfitter		11. BIRTHPLACE (City and state or country) St. Joseph, Mo.	
13a. FATHER'S NAME August Hager		13b. MOTHER'S MAIDEN NAME Mary Barbara Reiter	
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. 500-07-8016	
17. INFORMANT Address Mrs Geo. H. Hager 2312 Messanie City		14. NAME OF HUSBAND OR WIFE Veronica A.	
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 DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 2 yrs
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. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒	20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐	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 ☐ NOT WHILE AT WORK ☐		
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 1951 to 7/26/64 and last saw him alive on 7/26/64 Death occurred at 1:15 PM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE S.C. Benson M.D.		22b. ADDRESS 324 N. 60	
22c. DATE SIGNED 7/27/64		22d. DATE SIGNED (State) _____	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7-29-64	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City, town, or county) St. Joseph, Mo.
24. FUNERAL DIRECTOR H.O. Sidenfaden & Son		25. DATE RECD. BY LOCAL REG. July 28, 1964	
ADDRESS St. Joseph, Mo.		26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell	

USE BLACK INK
OR
TYPEWRITER RIBBON

Permit issued 7-28-64

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

Robert H. Apple

Licensed Embalmer No. 3308*

P. O. Address St. Joseph, 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.