

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 65 Primary Registration District No. 3010 Registrar's No. 10038837 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF	DATE AMENDED	DOCUMENT
Rev. 4/59			
1 <u>0168</u>		5/28/65	
2 <u>8120</u>		5/28/65	
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12 <u>3-0</u>			
13 <u>1-0</u>			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

Mae Hagler
332-14-6196

BY AFFIDAVIT OF Funeral Director

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Alexander</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cape Girardeau</u>			Length of stay in lb <u>5 days</u>	c. CITY OR TOWN <u>Olive Branche</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>S. E. Mo. Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>gen'l del</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mac</u> Middle <u>----</u> Last <u>Hagler</u>			4. DATE OF DEATH Month <u>5</u> Day <u>9</u> Year <u>65</u>	5. SEX <u>female</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>1-24-1901</u>	9. AGE (last birthday) <u>64</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	11. BIRTHPLACE (City and state or country) <u>Jackson Co., Illinois</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Benjamin Franklin Eaton</u>		13b. MOTHER'S MAIDEN NAME <u>Elizsbeth Forbusch</u>		14. NAME OF HUSBAND OR WIFE <u>E. L. Hagler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>332-14-6196</u>	17. INFORMANT <u>X.E.L. Hagler</u>	Address <u>olive Branche, Ill</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>Carcinoma of Breast & Metastases</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u>DUE TO (b)</u>							<u>DUE TO (c)</u>
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input 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 <u>5:43 p.m.</u> Month, Day, Year <u>5/9/65</u>	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 <u>7-64</u> to <u>5/9/65</u> and last saw her <u>alive</u> on <u>5/9/65</u> . Death occurred at <u>5:43 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Harold Hedings MD</u>			22b. ADDRESS <u>Cape Girardeau, Mo.</u>		22c. DATE SIGNED <u>5/10/65</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>5-11-65</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakland</u>	23d. LOCATION (City, town, or county) (State) <u>Carbondale, Illinois</u>				
24. FUNERAL DIRECTOR <u>W. C. Cain</u>		ADDRESS <u>Moore, Ill</u>	25. DATE RECD. BY LOCAL REG. <u>5-14-65</u>	26. REGISTRAR'S SIGNATURE <u>Dennis Kasten</u>			

USE BLACK INK OR TYPEWRITER RIBBON

MAR 9 1966

MAY 28 1965

MAY 28 1965

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 William T. Cain

Licensed Embalmer No. 10154 (ILL)
P. O. Address Moundas, ILL.

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.