4 1928

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

14575

1. PLACE OF DEATH
County St Francois — Registration District No. 774 — File No. 36
Township — Primary Registration District No. 4465 — Registered No.
City Flat River (No. ..... St. ..... Ward)

2. FULL NAME Carlisle Hahn
(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 24-1855

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
73	10	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mo.

PARENTS
10. NAME OF FATHER: Peter Yount
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Mo.
12. MAIDEN NAME OF MOTHER: Peggy Morrow
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Mo.

14. INFORMANT: J. N. Hahn
(Address) Flat River Mo.

15. FILED May 9, 1928. F. L. Keith, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-12- 1928

17. I HEREBY CERTIFY, That I attended deceased from 4-7- 1928, to 4-12- 1928, that I last saw her alive on 4-12- 1928, and that death occurred, on the date stated above, at 9:30 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchial Pneumonia
131
129 W
(duration) yrs. mos. 5 ds.

CONTRIBUTORY (SECONDARY): Interstitial Nephritis Chronic
(duration) 2 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? no. DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Viewed Remains
(Signed) C. L. Hyatt, M. D
, 19 (Address) Flat River Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Wood Lawn Cemetery — DATE OF BURIAL: 4/13 1928

20. UNDERTAKER: Raymond Caldwell — ADDRESS: Elvins Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.