

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

Do not use this space.

14187

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis* (No. *2837^a*) *Guvois* St. _____ Ward, _____

File No. _____

Registered No. **3521**

2. FULL NAME *Charles H. Hauert*

(a) Residence. No. *2837^a* *Guvois* St. *13* 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. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 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 *Bertha Hauert*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 13 1876*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
53 8 23

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Janitor*
(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) *Germany*

10. NAME OF FATHER *Carl H. Hauert*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

12. MAIDEN NAME OF MOTHER *Elizabeth Streben*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

14. INFORMANT *Bertha P. Hauert*
(Address) *2837^a Guvois Av.*

15. *ACC - 8 1930*
FILED *May 19 1930* REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 6th 1930*

17. I HEREBY CERTIFY, That I attended deceased from *Feb 28*, 1930, to *April 6*, 1930, that I last saw him... alive on *Apr. 6*, 1930, and that death occurred, on the date stated above, at *12 noon* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of liver and Stomach

46B
46E (duration) yrs. mos. ds.

CONTRIBUTOR (SECONDARY) *440* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH. *not known.*

1 DID AN OPERATION PRECEDE DEATH? *yes* DATE OF *Mar. 15, 1930*
WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Exploratory operation at City Hospital*
(Signed) *R. M. M. M. D.*
, 19 (Address) *2946 Gravois ave.*

*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 *Valhalla Cem.* DATE OF BURIAL *4-9 1930*

20. UNDERTAKER *Witt Bros. & Co. 2929 Gravois Av.* ADDRESS

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.

WHITE CERTIFICATE WITH DWARDING INK—THIS IS A PERMANENT RECORD

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