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

Do not use this space.

34889

File No. 791

Registered No. 10286

Registration District No. 1003

Primary Registration District No.

1. PLACE OF DEATH

County

Township

City St. Louis (No. 4224 Lexington St. Ward)

2. FULL NAME Fannie Hauck

(a) Residence. No. 4224 Lexington St., 10 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: Female

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: Herbert V. Hauck

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Sept. 18-1911

7. AGE: Years 19 | Months 1 | Days 10 | If LESS than 1 day, ____ hrs. or ____ min.

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

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

PARENTS

10. NAME OF FATHER: Roscoe Berle

11. BIRTHPLACE OF FATHER (CITY OR TOWN):
(STATE OR COUNTRY): Italy

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN):
(STATE OR COUNTRY): Italy

14. INFORMANT: Herbert V. Hauck
(Address) 4224 Lexington St.

15. FILED OCT 31 1930, 19 Mar G. Harlen
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Oct 28 1930

17. I HEREBY CERTIFY, That I attended deceased from 9-4-30, 19__, to 10-28, 1930, 19__, that I last saw he alive on 9-24-, 1930, 19__, and that death occurred, on the date stated above, at 9:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Pulmonary Tuberculosis

PTB

from history (duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (SECONDARY): None known

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
NOT AT PLACE OF DEATH? Same
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Tuberculin Tests
(Signed) W A McCaa, M. D.
, 19 (Address) 2806-N-12th St.

*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: Calvary Cemetery — DATE OF BURIAL: Oct. 30 1930

20. UNDERTAKER: Cullinane Bros — ADDRESS: 7018 Grand Ave

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD