

DEC 13 1937

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

40029
Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. **791**
(b) Township Primary Registration District No. **1003**
(c) City **St Louis** (d) Street No. **De Paul Hospital** St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred **40** yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. **1402^e Olive** St. **25** (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

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 **Otilda Hakius**
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **May 20 - 1890**
7. AGE YEARS **47** MONTHS **6** DAYS **7** If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Waiter**
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Rolla, Mo**

13. NAME **Joseph Hakius**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

15. MAIDEN NAME **Anna Miller**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St Louis, Mo**

17. INFORMANT (ADDRESS) **Mrs Otilda Hakius**
1402 Olive, St Louis Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE **National Cemetery** DATE **11-30-37**
Jeff Barracks

19. FUNERAL DIRECTOR (ADDRESS) **Mullen Bros**
4259 Lindell Blvd

20. FILED **NOV 30 1937** **J. Brebeck**
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Nov 27th**, 19**37**
22. I HEREBY CERTIFY, That I attended deceased from **11-16-37**, to **11-27-37**
I last saw him alive on **11-27-37**, 19**37**. Death is said to have occurred on the date stated above, at **11:30** a.m.
The principal cause of death and related causes of importance were as follows:

Generalized Peritonitis Date of onset **11-25-37**
Subequired to rupture in Chronic Cholecystitis & Abscess
Other contributory causes of importance:
Cholelithiasis Date of **11-26-37**
Pulmonary Embolism
Concussion due to wound rupture
(E.V.I.S. CERTIFICATION)
Name of operation **Cholecystectomy** Date of **11-17-37**
What test confirmed diagnosis? Was there an autopsy? **Yes**

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify **Intoxication** M. D.
(Signed) **J. Brebeck**
(Address) **4500 Olive St**

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

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.

STATEMENT BY LICENSED EMBALMER

I, Wm Rogers, Licensed Embalmer No. 3905-

hereby certify that the body recorded on the reverse side of this certificate was embalmed by myself

L. E.

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed Wm Rogers

Licensed Embalmer No. 3905-

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.)