

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.

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

16235  
Do not use this space.

MAY 18 1939

1. PLACE OF DEATH  
 (a) County Saline Registration District No. 7968  
 (b) Township \_\_\_\_\_ Primary Registration District No. 3038 Registered No. 81  
 (c) City Marshall (d) Street No. Fitzgibbons 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John Fall Haux  
 (a) Residence, No. 334 East North St.  (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 Martha Francisco

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 28, 1865

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>74</u>	<u>0</u>	<u>28</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retail shoe

9. Industry or business in which work was done, as saw mill, bank, etc. Merchant Retired

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) Missouri

FATHER

13. NAME Oliver Haux

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

MOTHER

15. MAIDEN NAME Elizabeth Belles

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

17. INFORMANT (ADDRESS) Marshall Haux  
St. Louis, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Ridge Park Cem. DATE April 27, 1939

19. FUNERAL DIRECTOR (ADDRESS) Campbell-Lewis  
Marshall, Mo.

20. FILED 4-29-39 Mary Kent  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 26, 1939

22. I HEREBY CERTIFY, That I attended deceased from Apr. 5 to Apr. 26  
 I last saw him alive on Apr. 25, 1939. Death is said to have occurred on the date stated above, at 8:20 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Acute perforating appendicitis Date of onset 4-5-39  
General peritonitis  
Appendicitis  
 Other contributory causes of importance: 121  
 Name of operation Appendectomy Date of 4-5-39  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? no

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? no  
 If so, specify \_\_\_\_\_  
 (Signed) Marshall Haux, M. D.  
 (Address) Marshall, Mo.

RECEIVED  
District Health Officer No. 8  
District File Number  
Date Filed 6/2/39

STATEMENT BY LICENSED EMBALMER

I, W. Campbell, Licensed Embalmer No. 3469

hereby certify that the body recorded on the reverse side of this certificate was embalmed by W. Campbell

..... L. E. ....

No. .... or by ..... Registered Apprentice No. ....  
working under my personal supervision:

Signed W. Campbell  
Licensed Embalmer No. 3469

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.)