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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 11 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6533

Registration District No. 295 Primary Registration District No. 4179 Registrar's No. 59

1. PLACE OF DEATH:

(a) County Franklin

(b) City or town Sullivan
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Residence
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 (Specify whether
In this community 18 Years.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin

(c) City or town Sullivan
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME John W. Hauck 200

3. (b) If veteran, name war .....

3. (c) Social Security No. 493-01-1412

4. Sex Male ~~White~~

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mae Haucke

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased Jan. 17 (Month) 1881 (Day) (Year)

8. AGE: Years 59 Months Days 15 If less than one day ..... hr. ..... min.

9. Birthplace Kentucky (City, town, or county) (State or foreign country)

10. Usual occupation Shoe-worker

11. Industry or business International Shoe Co.

FATHER
12. Name John Hauck
13. Birthplace Indiana (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mae Hauck
(b) Address Sullivan, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Fe. 4, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Sullivan, Mo.

18. (a) Signature of funeral director [signature]
(b) Address Sullivan, Missouri

19. (a) 2-3 1940 (Date received local registrar) (b) C A Proctor (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 2 year 1940 hour 10:00 minute A M.

21. I hereby certify that I attended the deceased from 1938 19.., to 2-2, 1940 that I last saw him alive on Jan 15, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma sigmoid — Duration 1 yr or more

Due to .....

Due to .....

Other conditions .....
(Include pregnancy within 3 months of death)

Major findings: Of operations May 39 - Obstruction sigmoid - Carcinoma. Colostomy
Of autopsy None

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) .....
(b) Date of occurrence .....
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? .....
(Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature C A Proctor (M. D. ~~or other~~)
Address Sullivan Mo Date signed 2-3-40

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Me

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Edgar W. Lafleur

Licensed Embalmer No. 3394

P. O. Address Sullivan Me

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.)

If this body is not embalmed, above space should be left blank.