

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.

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
 1940
 Registration District No. 784

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. 12327
 Registrar's No. 586

Primary Registration District No. 202

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town Creve Coeur
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Olive Street Rd.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community _____
 years, months or days 2 55

3. (a) PRINT FULL NAME Caroline Hackmann
 8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife John C. Hackmann 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased April 13 1857
 (Month) (Day) (Year)

8. AGE: Years 82 Months 11 Days 11 If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) Germany (State or foreign country) 6

10. Usual occupation Nil

11. Industry or business _____

MOTHER FATHER
 { 12. Name Wm Krueger
 { 13. Birthplace _____ (City, town, or county) Germany (State or foreign country) 6
 { 14. Maiden name UNKNOWN
 { 15. Birthplace _____ (City, town, or county) (State or foreign country) 9

16. (a) Informant's own signature John Hackmann

(b) Address 123 Edgac Rd Webster Groves

17. (a) Burial (b) Date thereof May 27 - 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Pauls Cem

18. (a) Signature of funeral director Louis Meyer Olive & Link
 (b) Address 131 W. Argonne Dr Kirkwood Mo

19. (a) MAR 25 1940 (b) DR Meyer
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
 (c) City or town Creve Coeur
 (If outside city or town limits, write "RURAL")
 (d) Street No. Olive St. Rd.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 24
 year 1940 hour (five) 5 minute 15 P. M.

21. I hereby certify that I attended the deceased from 11-27, 1939 to 3-24, 1940
 that I last saw her alive on 3-24, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronal Hemorrhage 5 days
 Due to arterio sclerosis (Renal) 1-year
 Due to Chronic myocarditis 1-year
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations 936
 Of autopsy _____
 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? _____

(e) While at work? _____ (Specify type of place)
 (f) Means of injury _____

23. Signature Wm J. Hademan (M. D. or other) M.D.
 Address 333 Metropolitan Bldg Date signed 3-25-40

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.....
John M Meyer....., Registered Apprentice No.....
working under my personal supervision.

Signed *John M Meyer*.....
Licensed Embalmer No. *3288*.....
P. O. Address *3404 Adams Ave*
Wishard, Mo

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.