

Registration District No. **689**

Primary Registration District No. **2033**

Registrar's No. _____

1. PLACE OF DEATH: **Pike**
 (a) County **Louisiana**
 (b) City or town **Louisiana**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **210 N. 4th St.** **2**
(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 **230**

3. (a) PRINT FULL NAME **Peter T Haught**
 3. (b) If veteran, name war
 3. (c) Social Security No.

4. Sex **Male** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Ellie B Haught**
 6. (c) Age of husband or wife if alive **69** years

7. Birth date of deceased: **8** (Month) **24** (Day) **60** (Year)

8. AGE: Years **79** Months **7** Days **11**
 If less than one day _____ hr. _____ min.

9. Birthplace **W Va**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Farmer**

11. Industry or business _____

MOTHER FATHER
 { 12. Name **Michael Haught**
 { 13. Birthplace **W Va**
 { 14. Maiden name **Matilda Moore**
 { 15. Birthplace **W Va**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Miss Ruth Johnson**
 (b) Address **Louisiana Mo**

17. (a) **Burial** (b) Date thereof **4/7-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Reviewers Louisiana Mo**

18. (a) Signature of funeral director **J. Haught**
 (b) Address **Louisiana Mo**

19. (a) **4/6/40** (b) **J. Haught**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo** (b) County **Pike**
 (c) City or town **Louisiana**
(If outside city or town limits, write "RURAL")
 (d) Street No. **210 N. 4th**
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **April** day **5**
 year **1940** hour **6** minute **45 P.M.**

21. I hereby certify that I attended the deceased from **April 1, 1940**, 19 to **April 5, 1940** including that I last saw him alive on **April 6, 1940**, 19 and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Uremia** **5 days**
 Due to **Chr. Cardio-Nephritic Disease**

Due to **Chronic Myocarditis & Chronic Constipation**

Other conditions **Chronic Myocarditis & Chronic Constipation**

Major findings: **X**
 Of operations _____
 Of autopsy _____

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? **696**

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

23. Signature **R. L. Hedrae** (M. D. or other) **M.D.**
 Address **Louisiana Mo** Date signed **4/6/40**

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.

1939

RECEIVED

District Health Officer No. 10

District File Number 5-40-954

Date Filed MAY 8 1940

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.....

George O. Wagner, Registered Apprentice No.....
working under my personal supervision.

Signed George O. Wagner
Licensed Embalmer No. 3773
P. O. Address Louisiana, 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.