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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

JUN 1 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17868

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 509

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

1. PLACE OF DEATH:

(a) County Buchanan,

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

(c) Name of hospital or institution:
529 North 24th. Street, 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 45 years,
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County Buchanan,

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

(d) Street No. 529 North 24th. Street,
(If rural, give location)

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

3. (a) PRINT FULL NAME Charles Robert Hauck 2nd

3. (b) If veteran, name war None,

3. (c) Social Security No. None,

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Sadie B. Hauck,

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased August 14, 1874
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
65	8	19	___ hr. ___ min.

9. Birthplace New Kingston, Pennsylvania,
(City, town, or county) (State or foreign country)

10. Usual occupation Optometrist,

11. Industry or business Optical,

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

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

16. (a) Informant Mrs. Chas. R. Hauck

(b) Address 529 North 24th. Street,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/7/40
(Month) (Day) (Year)

(c) Place: burial or cremation Mt. Auburn Cemetery

18. (a) Signature of funeral director Healon - Wiele Bowman Funeral

(b) Address 319 So. 10th. Str. Home

19. (a) May 6 1940 (Date received local registrar) (b) H. J. Westlebud (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 3rd.
year 1940 hour 4:00 minute 30p M.

21. I hereby certify that I attended the deceased from Apr 12, 1940, to May 3, 1940;
that I last saw her alive on May 3, 1940;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Thrombosis	
Due to Coronary heart disease	
Due to Arteriosclerotic heart disease.	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations /	
Of autopsy /	

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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?
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(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature H. S. Conrad (M. D. ~~or other~~) 1

Address St Joseph Mo. Date signed 5-4-40

(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 ✓ ....., Registered Apprentice No. ..... working under my personal supervision.

Signed Wm E Summerfield

Licensed Embalmer No. 3007

P. O. Address 319 S. 10 St Joseph

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

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