

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. **27854**

Registration District No. **36**

Primary Registration District No. **5052**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Barry**
 (b) City or town **Seligman**
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **2**
 In this community **50 yrs.**
 years, months or days

8. (a) PRINT FULL NAME **Susan Jackson Haneke**

8. (b) If veteran, name war _____ 3. (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 L. Haneke**
 6. (c) Age of husband or wife if alive **5** years
 Birth date of deceased **July 1861**
 (Month) (Day) (Year)

8. AGE: Years **79** Months **1** Days **1**
 If less than one day hr. _____ min. _____

9. Birthplace **Marionville Mo.**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **Home**

MOTHER FATHER
 { 12. Name **Marion Collier**
 13. Birthplace **Tennessee**
 (City, town, or county) (State or foreign country)
 { 14. Maiden name **Elvira Burrows**
 15. Birthplace **Tennessee**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. W. M. Wardlow**
 (b) Address **Seligman, Mo.**

17. (a) **Burial** (b) Date thereof **Aug 8, 1940**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New Salem Cem.**

18. (a) Signature of funeral director **Roon Funeral Home**
 (b) Address **Crossville Mo.**

19. (a) **8-8-1940** (b) **Pollie S. Frost**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Barry**
 (c) City or town **Seligman**
 (If outside city or town limits write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **6**
 year **1940** hour **11:15** minute **7** A.M.

21. I hereby certify that I attended the deceased from **Aug. 5th**, 19**40**, to **Aug 6**, 19**40**
 that I last saw h.w.a. alive on **Aug 6**, 19**40**
 and that death occurred on the date and hour stated above.

Immediate cause of death: **Coronary thrombosis -**
hemorrhage -
 Due to **arteriosclerosis**

Duration **2 days**
4 7/8
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) **HTF**

Major findings: 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? **35**

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

23. Signature **H. W. Edwards** (M. D. or other) **1**
 Address **Seligman** Date signed **8/7**

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

5

W. Edwards

RECEIVED
District Health Officer No. 6,
District File Number
Date Filed

RECEIVED

District Health Officer No. 6,

District File Number 940-2565

Date Filed SEP 10 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.....

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

working under my personal supervision.

Signed Eugene Wood

Licensed Embalmer No. 3804

P. O. Address Cassville, 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.