No. 2
-4-13-40
5-17-39
I X23159

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 33988

Registration District No. 791 Primary Registration District No. 1003

Registrar's No. 8685

FILED NOV 16 1940

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: 5305 Gilson Ave. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County

(c) City or town St. Louis 15
(If outside city or town limits, write "RURAL")

6

(d) Street No. 5305 Gilson Ave.
(If rural, give location)

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

3. (a) PRINT FULL NAME John Hacay

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Late Veronica Hacay

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

7. Birth date of deceased May (Month) 17th (Day) 1869 (Year)

8. AGE: Years 71 Months 5 Days 4 If less than one day hr. min.

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

10. Usual occupation Unemployed Laborer 6

11. Industry or business

FATHER
12. Name Unknown Hacay 4
13. Birthplace Unknown (City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs Mayme Stone
(b) Address 5305 Gilson Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-23-40 (Month) (Day) (Year)
(c) Place: burial or cremation Old St Peter & Paul

18. (a) Signature of funeral director Kriegshauser Mortuaries
(b) Address 4228 So. Kingshighway Blvd

19. (a) OCT 21 1940 (Date received local registrar) (b) J. Ambrich (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 21st year 1940 hour 1:30 minute A. M.

21. I hereby certify that I attended the deceased from Sept. 29, 1940, 19..., to Oct. 21, 1940, 19..., that I last saw him alive on Oct 21, 1940, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy — Duration 1 day

Due to 93C

Due to

Other conditions Rt Hemiplegia — 1 Month
(Include pregnancy within 3 months of death) Chronic Myocarditis-arteriosclerosis

Major findings:
Of operations

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

23. Signature Ska Simpson (M. D. or other) M.D.
Address 3739 Gravois Date signed 10/21/40

(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 Edwin A. McDermott

Licensed Embalmer No. 3024

P. O. Address.....

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

If this body is not embalmed, fact should be so stated above.