

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

36450
State File No.
Registrar's No. 1923

Registration District No. 284

Primary Registration District No. 200

1. PLACE OF DEATH:

(a) County Saint Louis
(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Veterans Administration Facility
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Adm: 10-8-40
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT

FULL NAME Joseph A. HACKEY

3. (b) If veteran,

name war World

3. (c) Social Security

No. Unkn.

4. Sex Male

5. Color or
race White

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

6. (b) Name of husband or wife -

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

7. Birth date of deceased December 19, 1890
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
49 9 20 hr. min.

9. Birthplace Saint Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Watchman

11. Industry or business -

12. Name Christopher Hackey

13. Birthplace Ohio
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Jane French

15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Clinical Clerk Schullig

(b) Address VAF, Jefferson Barracks, Missouri

17. (a) Burial (b) Date thereof Oct 18, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation VAF

18. (a) Signature of funeral director [Signature]

(b) Address OCT 11 1940

19. (a) OCT 11 1940
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Saint Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2940 North Prairie Avenue
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 9
year 1940 hour 9 minute 50 PM M.

21. I hereby certify that I attended the deceased from October
8, 19 40 to October 9, 19 40;

that I last saw him alive on October 9, 19 40;
and that death occurred on the date and hour stated above.

Immediate cause of death Cirrhosis of the liver Duration
and

Nephritis, chronic, with edema
and nitrogen retention. Unkn.

Due to 124 h

Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
Of operations No operation

Of autopsy No 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?

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

23. Signature C.W. HUGHES, MD Chief Medical Officer
Address VAF Jefferson Bks., Mo. Date signed 10-10-40

(Licensed Embalmer's Statement on Reverse Side)

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

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

B. M. F.

Licensed Embalmer No. *1591*

P. O. Address *4106-9 Bot...*

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, fact should be so stated above.