No. 2
4-13-40
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED JUN 13 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17563

Registration District No. 198 Primary Registration District No. 3011 Registrar's No. 64

1. PLACE OF DEATH:
(a) County: Clay
(b) City or town: Excelsior Springs (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: EXCELSIOR OSTEOPATHIC SANITARIUM, INC. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days (Specify whether years, months or days) In this community 8 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Iowa (b) County: Benton
(c) City or town: Blairstown (If outside city or town limits, write "RURAL") 13
(d) Street No.: ✓ (If rural, give location)
(e) If foreign born, how long in U. S. A.? 50 — 3 years.

3. (a) PRINT FULL NAME: CHARLES HAUBOLD
3. (b) If veteran, name war: No
3. (c) Social Security No.: No
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: Unknown (Month) (Day) (Year)
8. AGE: Years: about 83 Months: Days: If less than one day: hr. min.
9. Birthplace: unknown (City, town, or county) Germany (State or foreign country)
10. Usual occupation: Retired Poultry Dealer
11. Industry or business: ✓
12. FATHER Name: unknown
13. FATHER Birthplace: Germany (City, town, or county) (State or foreign country)
14. MOTHER Maiden name: unknown
15. MOTHER Birthplace: Germany (City, town, or county) (State or foreign country)
16. (a) Informant: E. E. Crouston
(b) Address: Blairstown, Iowa.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 5-7-41 (Month) (Day) (Year)
(c) Place: burial or cremation: Blairstown, Iowa
18. (a) Signature of funeral director: Herbert Hope
(b) Address: Excelsior Springs, Mo.
19. (a) May 8-1941 (Date received local registrar) (b) Mo Rea McCracken (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: May day: 6 year: 1941 hour: 8 minute: 47 P.M.
21. I hereby certify that I attended the deceased from May 3, 1941, to May 6, 1941, that I last saw him alive on May 6, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemorrhage	4 days
Second attack	
Due to: Cerebral Hemorrhage	10 yrs.
Partial Heart Block due	?
Due to: Arteriosclerosis	
Other conditions (Include pregnancy within 3 months of death)	
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: Miles H. Puttan (M. D. or other) D.O.
Address: Excelsior Springs, Mo Date signed: 5/7/41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District-File Number 6-12-41
Date Filed

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 Scott W. Hockensmit

Licensed Embalmer No. 3597

P. O. Address Excelsior Spring

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

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