

FILED OCT 7 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 32630

Registration District No. 289

Primary Registration District No. 200

Registrar's No. 1904

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Koch  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Robert Koch Hospital  
(If not in hospital or institution, write street number of location)  
(d) Length of stay: In hospital or institution Two weeks (Specify whether  
In this community 45 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1402 Woodland  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 12  
year 1941 hour 5 minute 45 P. M.  
21. I hereby certify that I attended the deceased from July  
28th, 1941, to Sept 12, 1941  
that I last saw him alive on Sept 12, 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Tuberculosis of lungs Duration  
7 yrs

Due to \_\_\_\_\_  
Due to 13 hrs

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy None  
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?  
While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Robert Koch Hospital (M. D. or other) \_\_\_\_\_  
Address Robert Koch Hospital Date signed 9/14/41

3. (a) PRINT FULL NAME JOHN HAKERTY

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 225-22-4313

4. Sex M (1) 5. Color or race W 6. (a) Single, widowed, married, divorced M /

6. (b) Name of husband or wife Louise Rice 6. (c) Age of husband or wife if alive unknown years

7. Birth date of deceased. August 4 1895  
(Month) (Day) (Year)

8. AGE: Years 46 Months 1 Days 8 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace St. Louis (City, town, or county) U Mo. (State or foreign country)

10. Usual occupation Bank Teller

11. Industry or business banking

12. Name Michael Hakerty

13. Birthplace New Haven (City, town, or county) U Mo. (State or foreign country)

14. Maiden name Johanna Bruner

15. Birthplace St. Louis (City, town, or county) U Mo. (State or foreign country)

16. (a) Informant Hospital Records

(b) Address Robert Koch Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 15 1941  
(Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem

18. (a) Signature of funeral director Optimistic Funeral Home

(b) Address 9222 Lasker Ave, Oakland, Mo

19. (a) SEP 12 1941 (Data received local registrar) (b) L. M. Lawrence (Registrar's signature)

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

MOTHER FATHER

6  
0  
0

10-8

AUG 21 1952

**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 F. A. Williamson

Licensed Embalmer No. 3565

P. O. Address 7401 Zephyr Pl

**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.**