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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **32938**
Registrar's No. **7890**

Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital #1 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Day
(Specify whether _____)
In this community 33yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 066
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 119
(d) Street No. 3225 Montgomery St. (If rural, give location) 0
(e) Citizen of foreign country? Yes (Yes or No) 0
If yes, name country Germany

3. (a) PRINT FULL NAME Otto Hacke

3. (b) If veteran. name war Unknown
3. (c) Social Security No. Unknown

4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Unknown?
6. (b) Name of husband or wife Unknown
6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years 68 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Germany 4
(City, town, or county) (State or foreign country)

10. Usual occupation Nil.

11. Industry or business Nil.

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Ann Morrison

(b) Address St. Louis City Hospital #1

17. (a) _____ (b) Date thereof 9-8-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. OCT 3 1941 (Date received local registrar) (b) _____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 4
year 1941 hour 12:15 minute P. M.

21. I hereby certify that I attended the deceased from September 3, 1941 to September 4, 1941; that I last saw him alive on September 4, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerosis

Due to _____
Due to _____

Other conditions M
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

Duration

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) (b) Means of injury _____

23. Signature [Signature] (b) _____ (M.D. or other)
Address 1525 Lafayette Avenue Date signed 8/15/41

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

MOTHER FATHER

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.....

Licensed Embalmer No.....

P. O. Address.....

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.