No. 2
-41
7-39
X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 14 1941

Registration District No. 85

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1001

State File No. 34346

Registrar's No. 1002

1. PLACE OF DEATH:

(a) County: Buchanan

(b) City or town: St. Joseph City

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1810 S.20th St.

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: None

In this community: 53 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Buchanan

(c) City or town: St. Joseph

(If outside city or town limits, write "RURAL")

(d) Street No.: 1810 S.20th St.

(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: John Rubert Hauber

3. (b) If veteran, name war: None

3. (c) Social Security No.: None

4. Sex: Male

5. Color or race: White

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

6. (b) Name of husband or wife: Katharina Hauber

6. (c) Age of husband or wife if alive: 72 years

7. Birth date of deceased: March (Month) 24 (Day) 1864 (Year)

8. AGE: Years 77 Months 6 Days 26 If less than one day: hr. min.

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

10. Usual occupation: Farmer

11. Industry or business:

FATHER

12. Name: Frank A. Hauber

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

MOTHER

14. Maiden name: Josephine Sing

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

16. (a) Informant: Ursula K. Hauber

(b) Address: 1810 S.20th St. St. Joseph, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct. 22, 1941 (Month) (Day) (Year)

(c) Place: burial or cremation: Mt. Olivet Cemetery

18. (a) Signature of funeral director: Vernon W. Schuefaker

(b) Address: 1802 Union Str. St. Joseph, Mo.

19. (a) 10-28-1941 (Date received by local registrar) (b) H. Nestebush (Registrar's signature) L.E.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 20th year 1941 hour 10 minute 10 A.M.

21. I hereby certify that I attended the deceased from June 19, 41. 19..., to Oct 20, 19 41. that I last saw him alive on Oct. 19 19 41 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Carcinoma of Bile duct	
Due to	
Due to Carcinoma of Liver	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations: no operation

Of autopsy: as above

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): none

(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: J. G. Thomp... M.D. (M.D.)

Address: 821 Charles St. Joseph Date signed: 10-20-41

(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 Albert R. Harrington

Licensed Embalmer No. 3258

P. O. Address St. Joseph, Mo

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.

S. No. 2B
M—8-21-41
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

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STANDARD CERTIFICATE OF DEATH

State File No. 34346

Registration District No. 85 Primary Registration District No. 1001 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME John R. Hauber
3. (b) If veteran, name war U
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Mar 24 1864 (Month) (Day) (Year)
8. AGE: Years 77 Months 6 Days 26 If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 20 year 1941 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma of Bile duct	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations H6F	
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 H. G. Thompson (M. D. or other)
Address Date signed

SUPPLEMENTARY

E. 25 Charles St Joseph Mo.