

FILED JAN 20 1948
Registration District No. **10**

Primary Registration District No. **(10)**

Registrar's No. **27**

1. PLACE OF DEATH:

(a) County **MO. CLAYTON**

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

(c) Name of hospital or institution:
2642 WESTMORLAND AVE
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **96**

(c) City or town **CLAYTON**
(If outside city or town limits, write "RURAL") **3**

(d) Street No. **2642 WESTMORLAND**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **FRANCIS RUSSELL HAUSMANN**

3. (b) If veteran, name war _____

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 **MARY HAUSMANN** 6. (c) Age of husband or wife if alive **49** years

7. Birth date of deceased **APRIL 17 1885**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	56	9	8	hr. _____ min.

9. Birthplace **MO.** (City, town, or county) (State or foreign country)

10. Usual occupation **LAWTON BYRNE BRUNER INSUR. CO.**

11. Industry or business **Sec'y.**

12. Name **JOS. S. HAUSMANN**

13. Birthplace **MO.** (State or foreign country)

14. Maiden name **MARY MOHAN.** (State or foreign country)

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

16. (a) Informant **Mary Hausmann**

(b) Address **2642 WESTMORLAND**

17. (a) **BURIAL** (b) Date thereof **1-12-42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **CALVARY**

18. (a) Signature of funeral director **L. M. Mullen**

(b) Address **5165 DELMAR BLVD.**

19. (a) **JAN 10 1942** (b) **J. M. Mullen**
(Date received local registrar) (Registrar's signature)

(Licensed Embalmers' Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **9th**
year **1942** hour **12** minute **45 A.M.**

21. I hereby certify that I attended the deceased from **Dec 10th 1941** to **Jan 9th 1942**
that I last saw him alive on **Dec 28 1941**
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Artery Occlusion**

Due to _____

Due to **9/4/42**

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

Major findings: Of operations **None**

Of autopsy **not made**

Duration **10 hours**

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) Means of injury _____

23. Signature **Joseph Davie** (M. D. or other) **D**
Address **Country Bldg** Date signed **1942**

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

6
7
8

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

A. J. Harris

Licensed Embalmer No.

3384

P. O. Address

St Louis

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.