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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 25 1942

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 10391

Registration District No. 104 Primary Registration District No. 3008 Registrar's No. 124

**1. PLACE OF DEATH:**
(a) County Callaway
(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hosp. #1 7 Fulton Mo. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6-30-38 to 4-7-42 (Specify whether
In this community years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Mo. (b) County St Louis 014 1 2
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No. Riverside Drive
(If rural, give location)
(e) If foreign born, how long in U. S. A.? DK. 0 years.

3. (a) PRINT FULL NAME ELISABETH HAUSER
3. (b) If veteran, name war DK. 3. (c) Social Security No. DK.
4. Sex Female 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 DK. (Month) DK. (Day) 1874 (Year)

8. AGE: Years 67 Months DK. Days DK. If less than one day hr. min.

9. Birthplace (City, town, or county) Germany 4 (State or foreign country)
10. Usual occupation none
11. Industry or business
MOTHER FATHER
12. Name DK.
13. Birthplace DK. (City, town, or county) 9 (State or foreign country)
14. Maiden name DK.
15. Birthplace DK. (City, town, or county) 9 (State or foreign country)
16. (a) Informant Incomplete Hosp records
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof April 10-1942 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ Hospital Grounds
18. (a) Signature of funeral director C. L. Thomas
(b) Address 302 Market St Fulton Mo
19. (a) 4-10-42 (Date received local registrar) (b) Josie Morrison Klioff (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 4 day 7 year 1942 hour 2 minute P. M.
21. I hereby certify that I attended the deceased from Jan 1, 1941, to April 7, 1942 that I last saw her alive on April 7, 1942 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Primary Carcinoma of Caecum | ? |
| Due to | |
| Due to 46 | |
| Other conditions General Peritonitis and acute Endocarditis (Include pregnancy within 3 months of death) | |

Major findings:
Of operations
Of autopsy The above findings

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 0
23. Signature P. S. Tate (M. D. or other)
Address State Hosp. #1, Fulton Date signed 4-9-42

1147 (Licensed Embalmer's Statement on Reverse Side)

APR 28 1942

## 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.**