

No. 2
4-41
439
29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

20594
State File No. 305-24
1381

FILED APR 25 1942
Registration District No. 39-9 147 Primary Registration District No. 10-0-2 556-1 Registrar's No.

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution:
7001 Sycamore
(d) Length of stay: In hospital or institution: 60 Years
In this community 60 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(d) Street No. 7001 Sycamore
(e) Citizen of foreign country No

3. (a) PRINT FULL NAME Mr. John Charles Hauck

3. (b) If veteran, name war No 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 Mrs. Annette Hauck 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased: April 7 1865

8. AGE: Years 76 Months 11 Days 27 If less than one day hr. min.

9. Birthplace St. Louis Missouri

10. Usual occupation Grocery Owner Hauck Groce

11. Industry or business 6800 Independence Avenue

12. Name Rheinhold Hauck

13. Birthplace Germany

14. Maiden name Charlotte Miller

15. Birthplace Germany

16. (a) Informant Mrs. Annette Hauck

(b) Address 7001 Sycamore

17. (a) Cremation (b) Date thereof Apr. 7, 1942

(c) Place: burial or cremation D. W. Newcomer's Sons

18. (a) Signature of funeral director D. W. Newcomer's Sons

(b) Address 1401 Brush Creek Blvd.

19. (a) 4-7-42 (b) [Signature]

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 4th year 1942 hour 11 minute 40 P. M.

21. I hereby certify that I attended the deceased from 1-1, 1941, to 4-4, 1942 that I last saw 2 alive on 4-4- 1942 and that death occurred on the date and hour stated above.

Immediate cause of death: Obstruction of Coronary Artery Duration 10 min

Due to: Arteriosclerosis of a 2250

Due to: Cerebral Hemorrhage 195.

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

Major findings: None Of operations: None Of autopsy: None

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 [Signature] (M. D. or other) _____

Address [Address] Date signed 4-7-42

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

MOTHER FATHER

St. Luke Hospital
Commerce, Mo

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

Carle M. Calhoun

Licensed Embalmer No.

3506

P. O. Address

K. C. 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.

No. 2B
-8-21-41
X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 144

Primary Registration District No. 5569

Registrar's No. 1381

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Brookings
(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
In this community _____ years, months or days)

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 Charles Houck
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day _____ year 1942 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

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 apr (Month) 12 (Day) 1904 (Year)

8. AGE: Years 76 Months 11 Days 14 (If less than one day _____ min.)

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

10. Usual occupation _____

11. Industry or business _____

MOTHER, FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 4 (b) _____ (Registrar's signature)
(Date received local registrar)

Duration _____
Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
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 _____ (M. D. or other)
Address _____ Date signed _____

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

SUPPLEMENTARY

1159

30504