

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

24240

Do not use this space.

FILED AUG 13 1943

1. PLACE OF DEATH

(a) County Cudrair Registration District No. 7

(b) Township Martinsburg Primary Registration District No. 4020 Registered No. _____

(c) City _____ (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____

(e) Length of residence in city or town where death occurred _____ yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME William John Hahn

(a) Residence, No. _____ St. (If nonresident, give city or town and State) _____

(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 1 - 1904

7. AGE YEARS 39 MONTHS 6 DAYS 27 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at home

9. Industry or business in which work was done, as saw mill, bank, etc. same

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation 2

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Martinsburg Mo

FATHER

13. NAME Joseph A Hahn

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cudrair Mo

MOTHER

15. MAIDEN NAME Anna Duesler

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cudrair Mo

17. INFORMANT (ADDRESS) Joe Hahn

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE St. Peter's Church 7-31-43

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. T. McCall Wellsville Mo

20. FILED July 29 1943 Mary C. Jacoby Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 28 19 43

22. I HEREBY CERTIFY, That I attended deceased from July 16 19 43 to July 28 19 43

I last saw him alive on July 28 19 43. Death is said to have occurred on the date stated above, at 11.55 P.M.

The principal cause of death and related causes of importance were as follows:

Myocarditis

Date of onset 7-20-43

Other contributory causes of importance: Acute nephritis

Date 7-16-43

Name of operation None Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify _____

(Signed) W. T. McCall M. D. (Address) Ladonia Mo.

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

5008

RECEIVED

District Health Officer No. 10

Statist File Number 4-43-1390

Date Filed AUG 11 1943

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, _____, Registered Apprentice No. _____ working under my personal supervision.

Signed *W.B. Kellogg*

Licensed Embalmer No. 1584

P. O. Address *Kelloggville, N.Y.*

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, above space should be left blank.

Registration District No. 7 Primary Registration District No. 4020 Registrar's No. _____

1. PLACE OF DEATH:
(a) County Audrain
(b) City or town Martinsburg
(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 Wm John Hahn
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July 28
year 1943 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____;
_____ 19____;

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ year
7. Birth date of deceased: Feb (Month) 1 (Day) 1905 (Year)

that I last saw him _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death Myocarditis Duration _____

8. AGE: Years 39 Months 6 Days _____ If less than one day _____ min.

Due to _____
Due to _____

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

Other conditions acute nephritis
(include pregnancy within 3 months of death)

10. Usual occupation _____

Major findings following Chronic nephritis
Of operations _____

11. Industry or business _____

Of autopsy 1316

12. Name _____

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

14. Maiden name _____ (City, town, or county) (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

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 W H McCall (M. D. or other) _____

Address Saddonia Mo Date signed _____

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

SUPPLEMENTAL

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

5-24240