

FILED SEP 28 1943
Registration District No. **218**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town **Saint Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **BARNES HOSPITAL**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **0**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Haubrock, Fried**
(b) If veteran, name war **Nil**
(c) Social Security No. _____

4. Sex **Male** 0 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife **Nil**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Unknown**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
Abt. 68 hr. min.

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

10. Usual occupation **Harness maker**

11. Industry or business

MOTHER FATHER

12. Name **Caspar Haubrock**
13. Birthplace **Unknown Germany**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Frank Tieman**
(b) Address **Quincy, Illinois**
17. (a) **Removal** (b) Date thereof **9-19-43**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Quincy, Illinois**

18. (a) Signature of funeral director **Albert H. Hoppe**
(b) Address **4700 Washington Ave**
19. (a) **SEP 20 1943** (b) **F. J. Furedach**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Illinois** (b) County **Adams**
(c) City or town **Quincy**
(If outside city or town limits, write "RURAL")
(d) Street No. **1120 Payson**
(If rural, give location)
(e) Citizen of foreign country, **No.** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.**, day **19**
year **1943** hour **11** minute **15 A.M.**
21. I hereby certify that I attended the deceased from **Sept. 13**
_____, 19**43**, to **Sept. 19**, 19**43**
that I last saw him alive on **Sept. 19**, 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary heart failure**
& Pulmonary edema Duration _____

Due to **Coronary heart disease**

Due to _____

Other conditions **4/2**
(Include pregnancy within 3 months of death)

Major findings: **Benign hypertrophy of prostate**
Of operations **tricuspid infarct**
Of autopsy **Pulmonary valve stenosis**
& hypertrophy of heart

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)
(e) Means of injury _____

23. Signature **M. C. Albery** (M. D. or other) _____
Address **BARNES HOSPITAL** Date signed **9/19/43**

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 W. W. Wilkinson
Licensed Embalmer No. 3575

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.