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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 13 1944
Registration District No. 260

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43217
State File No. 43217
Primary Registration District No. 5584 4393
Registrar's No. 4393

1. PLACE OF DEATH:
(a) County Osage
(b) City or town Westphalia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Residence of Alon Hincike
(If not in hospital or institution, write street number or location)
(d) Length of stay: in hospital or institution. 3 weeks (Specify whether
In this community 3 weeks years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Callaway
(c) City or town Holt Summit
(If outside city or town limits, write "RURAL")
(d) Street No. Rt. 1 (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 1

3. (a) PRINT FULL NAME John Morris Hiatte
3. (b) If veteran, name war No. 3. (c) Social Security No. No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Nov. day 5, year 1943 hour 2:45 minute P. M.
21. I hereby certify that I attended the deceased from Oct 30, 1943 to Nov 5, 1943
that I last saw him alive on Nov 5, 1943
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race Wh
6. (a) Single, widowed, married, divorced, widowed
6. (b) Name of husband or wife Alon Hincike 6. (c) Age of husband or wife if alive years
7. Birth date of deceased Nov 16, 1864
(Month) (Day) (Year)

Immediate cause of death Pneumonia Duration
Due to Heart Disease
Due to Arctic Regulation
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

8. AGE: Years 78 Months 11 Days 19 If less than one day hr. min.
9. Birthplace Bunge Mo.
(City, town, or county) (State or foreign country)
10. Usual occupation Chief Farmer

MOTHER FATHER
11. Industry or business
12. Name Jim Hiatte
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Mary Coulter
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
16. (a) Informant John Hiatte
(b) Address Holt Summit, Mo.
17. (a) Burial (b) Date thereof Nov 9, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Holt Hill
18. (a) Signature of funeral director Herman Sewin
(b) Address 700 Jefferson
19. (a) Nov. 9, 1943 Antonia Kliba
(Date received local registrar's certificate) (Registrar's signature)

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 W. W. Williams (M. D. or other)
Address Westphalia, Mo. Date signed 11/5/43

1284

(Licensed Embalmer's Statement on Reverse Side)

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

L. H. Anderson

Licensed Embalmer No.

3641

P. O. Address

J. M. B.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *Jan.*
Registrar's No. _____

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County *Osage*
(b) City or town *Waldphalia*
(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)

3. (a) PRINT FULL NAME *John M. Huatte*
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex *M* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *W*
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased *Nov. 16*
(Month) (Day) (Year)

8. AGE: Years *78* Months *11* Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month *Nov* Day *16* Year *1943* Hour _____ Minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; _____, 19____;

that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death *Phemionoma*
Zakhar
Heart disease
Due to *Arctic reorganization*

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

Major findings: Of operations _____
Of autopsy _____
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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. W. Weddman* (M. D. or other) _____
Address *Waldphalia, Mo.* Date signed *11/17/43*

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

SUPPLEMENTARY

MOTHER FATHER

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

S-43217