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M-5-43  
7. 5-17-39  
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THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 11471

FILED APR 12 1944

Registration District No. 12-900  
Primary Registration District No. 3041

Registrar's No. 26

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

1. PLACE OF DEATH:

(a) County Macon

(b) City or town Macon  
(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 Mo. (b) County Macon

(c) City or town Macon  
(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 Isaac W. Haun

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar., day 7, year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 1943, to Oct., 1943

4. Sex Male

5. Color or race W

6. (a) Single, widowed, married, divorced widower

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: Aug. 26 - 1856  
(Month) (Day) (Year)

that I last saw him alive on Mar. 6, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral arteriosclerosis Duration 2 yrs

8. AGE: Years 87 Months 6 Days 12 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to generalized arterio-sclerosis 15 yrs +

9. Birthplace Merer Co. Penn.  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Carpenter

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name John Haun

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

14. Maiden name Matilda Beruhart

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

16. (a) Informant Mrs. Lulu Walker

(b) Address Macon Mo

17. (a) Burial (b) Date thereof 3-9-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oakwood Macon, Mo

18. (a) Signature of funeral director Stephens & Gooding

(b) Address Macon Mo

19. (a) 3/29/44 (b) Mrs. B. Dunkler  
(Date received local registrar) (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 J. F. Turner (M. D. or other) \_\_\_\_\_  
Address Macon, Mo. Date signed 3-22-44

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 10

District File Number 4-44-732

Date Filed APR 8 1944

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 C. L. Stephens

Licensed Embalmer No. 3057

P. O. Address Macon, 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.