No. 2
-5-42
-17-39
X32073

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

18675

State File No. .....

FILED JUN 12 1944

Registration District No. .....

Primary Registration District No. 5778a

Registrar's No. .....

1. PLACE OF DEATH:

(a) County Miller

(b) City or town Meta, Mo. [illegible]
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 79 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Miller 66

(c) City or town Meta, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. .....
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME John Bernard Hake

3. (b) If veteran — name war .....

3. (c) Social Security No. —

4. Sex Male

5. Color or race White

6. (a) ~~Single~~, widowed, ~~married~~, ~~divorced~~ 2 Widowed

6. (b) Name of husband or wife Mary L Hake

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

7. Birth date of deceased November 21 1864
(Month) (Day) (Year)

8. AGE: Years 79 | Months 6 | Days 5 | If less than one day ..... hr. ..... min.

9. Birthplace Westphlia Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation retired Farmer

11. Industry or business .....

FATHER
12. Name Henry Hake
13. Birthplace Germany 4
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Catherine Wanburn
15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant Frank Brandt
(b) Address Meta, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 29, 1944
(Month) (Day) (Year)

(c) Place: burial or cremation St. Cecilia Cemetary

18. (a) Signature of funeral director H. H. Strop
(b) Address Meta, Mo.

19. (a) May 28, 1944 (Date received local registrar) (b) John G. Schwieterman (Registrar's signature)

499

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 26
year 1944 hour 9 minute — M.

21. I hereby certify that I attended the deceased from May 16, 1944, to May 26, 1944;
that I last saw him alive on May 26, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis
Diabetes Mellitus with
~~Due to~~ Chronic nephritis

Due to .....

Other conditions .....
(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

Duration

131 P

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 Henry G. Isenberg (M. D. ~~or other~~)
Address Meta Date signed 5-27/44

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
Miller County Health Dep't.
County File Number 44-55
Date Filed 6-9-44

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 H. H. Strop

Licensed Embalmer No. 2924

P. O. Address Meta Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

6. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 18675

Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

1. PLACE OF DEATH:

(a) County: Miller
(b) City or town: 2 miles from Iberia
(If outside city or town limits, write "RURAL" and name of township.)
(c) Name of hospital or institution: Their Post Office
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (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 B. Hake

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. (Month) 21 (Day) 1864 (Year)

8. AGE: Years 79 Months 6 Days ..... If less than one day: ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
14. Maiden name .....
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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 26 year 1944 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....;
that I last saw h..... alive on ..... 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death	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 .....

SUPPLEMENTARY