

**FILED AUG 9 1944**

Registration District No. **177**

Primary Registration District No. **3016**

Registrar's No. **174**

1. PLACE OF DEATH  
(a) County **Cole**  
(b) City or town **Jefferson City, Mo.**  
(c) Name of hospital or institution: **St. Mary's Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **2 weeks**  
In this community **40 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Cole**  
(c) City or town **Jefferson City, Mo.**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **133 W. High Street**  
(If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country **no**

3. (a) PRINT FULL NAME **Mrs. PHILIMENA HAUCK KOTT**  
3. (b) If veteran, name war  3. (c) Social Security No.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **July** day **30** year **1944** hour **7** minute **30 a.**

4. Sex **Female** 5. Color or race **white**  
6. (a) Single, widowed, married, divorced **widowed**  
6. (b) Name of husband or wife **Martin Hauck** 6. (c) Age of husband or wife if alive **48 years**  
7. Birth date of deceased **June 17, 1888**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Sept 27**, 19**44**, to **July 30**, 19**44**  
that I last saw her alive on **July 29**, 19**44**  
and that death occurred on the date and hour stated above.

8. AGE: Years **56** Months **1** Days **13** If less than one day **—** hr. **—** min.

Immediate cause of death **Myocardial failure**  
Due to **Cardio renal disease**

9. Birthplace (City, town, or county) **0** (State or foreign country)  
10. Usual occupation **Housewife**

Due to **Hypertension**  
Other conditions **(Bundled Branch Block)**  
(Include pregnancy within 3 months of death)

11. Industry or business **Self**  
12. Name **Charles Masoman**  
13. Birthplace **Bermain** (City, town, or county) (State or foreign country)  
14. Maiden name **Josephine Washier**  
15. Birthplace **Bermain** (City, town, or county) (State or foreign country)

Major findings: Of operations **13/a**  
Of autopsy

16. (a) Informant **Leo Hauck**  
(b) Address **Jefferson City, Mo.**  
17. (a) **Burial** (b) Date thereof **8/2/44**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **St. Peter's Cemetery**

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?

18. (a) Signature of funeral director **Sylvester White**  
(b) Address **Jefferson City, Mo.**  
19. (a) **8-1-44** (b) **Martha Richter**  
(Date received local registrar) (Registrar's signature)

While at work? (Specify type of place) (c) Means of injury  
23. Signature **J. A. Osmond, M.D.** (M. D. or other)  
Address **Jefferson City** Date signed **8-1-44**

MOTHER FATHER

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

888

Mo.

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 8-8-44

SEP 22 1952

**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.....

*Sylvester Dull*

Licensed Embalmer No.....

*43211*

P. O. Address.....

*Jefferson City*

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

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

Registration District No. 17

Primary Registration District No. 3016

Registrar's No. 174

1. PLACE OF DEATH:

(a) County Call  
(b) City or town Jefferson city  
(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 Philomena Hauerkott

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced u

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive 77

7. Birth date of deceased June 17 1888  
(Month) (Day) (Year)

8. AGE: Years 56 Months 1 Days 1 If less than one day \_\_\_\_\_ min.

9. Birthplace St. Elizabeth, Ma  
(City, town, or county) (State or foreign country)

10. Usual occupation St. Elizabeth, Ma

11. Industry or business

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_  
17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_  
19. (a) 2-12-44 (b) Anna Richter  
(Date received local registrar) (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 July 1944  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ 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 \_\_\_\_\_

COPYING BLACK INK—WEAR A PERMANENT RECORD

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