

FILED JUN 27 1945

Registration District No. **150**

Primary Registration District No. **5572**

1. PLACE OF DEATH:

(a) County **Jackson**

(b) City or town **Rural Prairie Twp**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Jackson County Emg. Hospital**
(If not in hospital or institution, write street number & locality)

(d) Length of stay: **4 days** (Specify whether in this community **8 years** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**

(c) City or town **Rural Prairie**
(If outside city or town limits, write "RURAL")

(d) Street No. **Jackson County Home for aged R #4 Indp. Av.**

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME **Henry Hackbarth**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **No**

4. Sex **Male** 5. Color or race **wh.**

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

6. (b) Name of husband or wife **No**

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

7. Birth date of deceased **December 15th 1865**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
80	4	7	hr. min.

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

10. Usual occupation **none**

11. Industry or business _____

MOTHER FATHER

12. Name **Carl Hackbarth**

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

14. Maiden name **Caroline Hardstock**

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

16. (a) Informant **Records Jackson County Home**

(b) Address **R.F.D. 4 - Independence Mo**

17. (a) **Burial** (b) Date thereof **5-20-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Leo's Summit Mo**

18. (a) Signature of funeral director **H. B. Langford**

(b) Address **Leo's Summit - Mo**

19. (a) **May 19-45** (Date received local registrar)

F. M. Schuler (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **22nd** year **1945** hour **7** minute **20 P.** M.

21. I hereby certify that I attended the deceased from **4-18-** **1945** 19. to **4-22-1945** 19. ;

that I last saw him alive on **4-22-1945** 19. ; and that death occurred on the date and hour stated above.

Immediate cause of death: **Intestinal obstruction 3 days severe hypochromic anemia.**

Due to **Carcinoma of Base of Cervix**

Due to **462**

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? _____

While at work? (Specify type of place) _____ (e) Means of injury _____

23. Signature **F. M. Schuler** (M. D. or other) _____

Address **7729 Campbell** Date signed **9-27-45**

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

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.....

Licensed Embalmer No.....

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.