

FILED DEC 12 1945

Registration District No. _____ Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Deaconess Hospital**
(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 **Dr. Samuel W. Hauck**
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** **Married**
6. (b) Name of husband or wife **Hildegard** **6. (c) Age of husband or wife if alive** **50** years
7. Birth date of deceased **June 26 1881**
(Month) (Day) (Year)

8. AGE: Years **64** Months **5** Days **6** If less than one day _____ hr. _____ min.

9. Birthplace **Affton Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Doctor**

11. Industry or business _____
12. Name **Phillip Hauck**
13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Hildegard E. Hauck**
(b) Address **6121 Simpson Ave.**

17. (a) (Burial, cremation, or removal) **Burial** **(b) Date thereof** **Dec. 6, 1945**
(Month) (Day) (Year)

(c) Place: burial or cremation **Sunset Burial Park**
18. (a) Signature of funeral director **Walter Alder**
(b) Address **3634 Gravois Avenue**

19. (a) DEC 4 1945 **J. F. Brodeur**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **St. Louis**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **6121 Simpson Ave.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **2**
year **1945** hour **5** minute **00** A. M.
21. I hereby certify that I attended the deceased from **Nov 15**
1945 to **Dec 30** **1945**
that I last saw him alive on **Nov 30** **1945**
and that death occurred on the date and hour stated above.

Immediate cause of death **Hemorrhage**
Duration _____

Due to **Extraction of Teeth**
Due to **Bleeding from the gums for the last year**
Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations: **1/5**
Of autopsy: _____
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 **E. S. Kuntz** (M. D. or other)
Address **3526 Washington** **Date signed** **12/3/45**

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..... *Robert Crocker*

Licensed Embalmer No. *2178*

P. O. Address *St. Louis, 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.